Doctoral Portfolio In Counselling Psychology

by
Mehmoona Ashiq

A portfolio submitted to The University of Wolverhampton for the Practitioner Doctorate: Counselling Psychology Award: D.Couns.Psych

May 2017

Mehmoona Ashiq
Doctoral Portfolio in Counselling Psychology

Research dossier

Exploring the mental health help-seeking experiences of British South Asian Women and using these findings in the development of an intervention

By Mehmoona Ashiq

Mehmoona Ashiq
Doctoral Portfolio in Counselling Psychology

Abstract

Research has shown that a high number of South Asian people suffer with mental health problems and that South Asian women specifically, are at high risk of attempting self - harm or suicide. However, there seems to be a low uptake of the mainstream services offered by the South Asian community as a whole, compared to their white counterparts. Furthermore, the existing literature in this area is scarce and focuses on identifying barriers that South Asian women face in accessing help.

This mixed methods study explored the mental health help seeking experiences of British born South Asian women. For the first part of the study, six (N=six) women who had successfully accessed therapy were interviewed and the qualitative data was analysed using Braun and Clarke's (2006) framework for thematic analysis. The main superordinate themes identified included: therapy as a positive experience, perseverance and persistence, need to know basis, fears about being judged, the need for more publicising and awareness, recovery as an ongoing process, medical professionals needing to be more proactive, developing autonomy and putting your own needs first, developing understanding and the importance of the first step. Various subordinate themes were identified for some of these main superordinate themes.

The second part of this study involved delivering a psycho educational workshop (which was partly based on the qualitative data generated in the first part of the study) to a group of South Asian women (N=25). Their attitude towards help seeking was measured before, immediately after and four weeks after the workshop using Fischer and Farina's (1995) Attitudes toward Seeking Professional Psychological Help Scale.

An ANOVA Test indicated a statistically significant difference in attitudes to help seeking before, immediately after and four weeks after the workshop.

This study helped to get a better understanding of the experiences of a marginalised group and demonstrated how such information can be used to develop new and innovative interventions that can be used with a client group that appear to have low levels of engagement with and referral to mental health services.

CONTENTS

Mehmoona Ashiq
Doctoral Portfolio in Counselling Psychology

DECLARATION

The research dossier or any part thereof has not been previously submitted in any form to the University or to any other body whether for the purposes of assessment, publication or for any other purpose (unless otherwise indicated). With the exception of any express acknowledgments, references and/or bibliographies cited in the work, I confirm that the intellectual content of the work is the result of my own efforts and of no other person, beyond the role expected of my research supervisors Dr Richard Darby and Dr Nicholas Banks.

Signature .....

Date .....

ACKNOWLEDGMENTS

I would like to thank my director of studies Dr Richard Darby for sharing my passion and believing in this research study from the very beginning; thank you for your support, patience and guidance throughout the process. Thank you to Dr Victoria Galbraith for her advice in the early stages of the research and to Dr Nicholas Banks for his immense support and guidance in the final stages of this study.

Thank you to the entire course team, my cohort, placement supervisors and clients that have played an important part in this journey.

I would also like to thank all the women who took part in this research study and helped me to bring it to life; I feel privileged and honoured that you shared your personal experiences with me. I salute you for the courage you have shown, and I hope that your stories will encourage others to come forward and access the help they need.

Finally, I would like to thank my family and friends for their love, support and never - ending words of encouragement; I hope I've made you proud. A special mention to Shabana; for supporting me throughout this process and believing in me more than I ever believed in myself.

Chapter 1

Introduction and structure of thesis

1.1 Introduction to the research

Counselling psychology is a profession that combines scientific psychological principles with the more therapeutic aspects of counselling and psychotherapy (Woolfe *et al*. 2010). Thus, counselling psychology training involves the development of a 'scientific practitioner', who can make use of evidence based practice in their clinical work, alongside a 'reflective practitioner', who is able to reflect on the interpersonal processes that occur when they are present with a client and developing a therapeutic relationship with them. One of the distinguishing factors of the counselling psychology profession is the integration of its humanistic phenomenological foundations with scientific and empirically strong evidence based inquiry, thus encouraging the development of a scientist –practitioner and a reflective-practitioner (Kasket 2012, Strawbridge & Woolfe, 2003).

Another imperative aspect of counselling psychology is conducting empirically based research that can lead to the development of knowledge and ideas that can be used to develop new ways of working and thinking that can benefit the profession as a whole (Woolfe *et al*. 2010). Although counselling psychologists can sometimes face tensions or conflicts in their attempts to combine the reflective practitioner and research practitioner elements of their identity (Jordan, 2009 & Wang & Guo 2011), the profession has always placed a strong emphasis on the role counselling psychology plays in the development of new research, helping to distinguish it as a credible profession in its own right, but also to improve job prospects in current employability contexts (Kasket & Gil- Rodriguez, 2011 & Moller 2011).

It is often argued that the underpinnings of counselling psychology are rooted in positive psychology which places emphasis on growth and development as opposed to pathology and cure. Positive psychology describes itself as focusing on positive experiences and traits within individuals and concepts such as courage, spirituality perseverance, hope and wisdom are at the heart of its core (Seligman & Csik-szentmihalyi, 2000). It also places importance on the conditions which allow for optimal human functioning (Gable & Haidt, 2005). The positive psychology influence on the development of counselling psychology in the UK can be seen in the emphasis it places on humanistic psychology and Rogerian counselling; approaches which emphasise self-actualisation, wellbeing, personal achievement and development across the lifespan. Although the connection between positive psychology and the development of counselling psychology in the UK is acknowledged, it is perhaps not as explicit as is the case for the counselling psychology professions in the US (Steffen, Vossler & Joseph, 2015).

There have been calls in recent years for counselling psychology to reconnect with its roots that lay in positive psychology and bring its focus back on human strength and positive development (Robitscheck & Woodson, 2006 & Vossler, Steffen & Joseph, 2015).

Joseph and Murphy (2013) suggest better collaboration between the two branches of psychology could lead to greater understanding and identifying better ways of conducting research and clinical practice. It can be argued that this research study, with its focus on the positive experiences of therapy and the positive traits that South Asian women from different religious and cultural groups were able to demonstrate access to therapy successfully, as opposed to what did not work for them or served as a barrier or obstacle in their recovery, is influenced and inspired by the underlying concepts of positive psychology.

1.2 Relevance of the present study

This research dissertation focuses on the mental health help seeking experiences of British South Asian women. The first part of the research will explore how this group of individuals successfully access therapeutic help. The current research aims to develop understanding of the help seeking experiences of a marginalised group in the UK (British South Asian Women) by exploring their help seeking experiences. This study will identify gaps in existing research in the area and examine how these can be filled with the present study. It will use the data generated from the initial part of the study to develop a psychological intervention that will be delivered and the impact of this on attitudes to help seeking measures. It is hoped that this latter part of the study will help generate ideas of working with a community, who literature suggests, experience high levels of mental distress and low levels of service uptake.

1.3 Paradigms and a mixed methods approach

A mixed methodology approach involves the combination of both quantitative and qualitative research methods and is sometimes referred to as the third wave of research methodology (Cresswell, 2006). It has the potential to develop a better understanding of research areas, especially those concerned with more complicated phenomena (Cresswell & Planto Clark, 2007 & Tashakkori & Teddlie, 2003). Furthermore, a mixed methods study can maximise the strengths and overcome the weaknesses of each approach (Tariq & Woodman, 2013 & Creswell *et al.* 2011).

A mixed methods approach was most suitable for this study because one approach alone was not sufficient in exploring the research topic and questions fully in depth.

Therefore, a qualitative approach (ideographic and emic), which focuses on unique individual experiences, would allow for the deeper exploration of the subjective experiences of South Asian women who had successfully accessed therapy. Alongside this, a quantitative approach (nomothetic) would need to be used in the second part of the study, which aimed to explore patterns in the attitudes towards help seeking following exposure to an intervention. Furthermore, there have been very few studies carried out with this particular group using a mixed methods approach; therefore, this study allows a new and innovative way of exploring and promoting help seeking experiences within this group.

Paradigms refer to the influences on the researcher when he or she chooses an area of study and the methods to be used in the collection and interpretation of results (Morgan, 2007). Teddlie & Tashakkori (2009, p.84) describe a paradigm as "a worldview, together with the various philosophical assumptions associated with that point of view." The quantitative approach is usually associated with the positivist paradigm whereas qualitative research is associated with the constructivism paradigm. One of the main issue researchers' face when choosing a mixed methods study, is identifying the rationale for the combination of both quantitative and qualitative approaches (Hall, 2012). There have been some arguments to suggest that the two remain incompatible (Guba & Lincoln, 1994).

Hall (2012) proposes that researchers wanting to use a mixed methods approach can take three positions when identifying the paradigm for their research. The first is the a-paradigmatic position which ignores the paradigm issue completely and sees methodology and epistemology as two separate things (Patton,1990). The second is the multiple paradigm position which proposes that more than one paradigm can be used in research. The third one is the single paradigm position which proposes that a single

paradigm can be selected which reflects both the quantitative and qualitative methods to be used. This position helps combat the issues that may arise from the first two approaches, such as not acknowledging epistemology or the confusion that may arise as a result of mixing paradigms that are too different. The pragmatism and the transformative approach are the two paradigms that have been identified as taking this third position. It is the latter which will form the foundations of this present study as it is used for research which focuses on the experiences of marginalized groups in society including women and ethnic minorities (Mertern, 2003).

The transformative paradigm provides a framework that is able to address social inequality and injustice. This position allows the use of both quantitative and qualitative data to be used to deal with the complexities that can arise when carrying out cultural research. Furthermore, it can provide a platform for bringing about change in society (Mertern, 2003). This paradigm position is most suited to the present study as it aims to develop new insights into the experiences of a marginalised group, and then use these insights to deliver an intervention with the hope that it will bring about a positive change in attitudes which could have implications for society as a whole.

1.4 Structure of thesis

Chapter two will review literature regarding the mental health status and help experiences of British South Asian women. It will critique the existing literature in this area and provide a summary of it. It will conclude by describing the relevance of the present study and outline its main aims and objectives.

Chapter three will present the qualitative element of the study in its entirety. This part of the study involved carrying out interviews with six participants. The chapter will

include an introduction, methodology and results section. The chapter will conclude with a summary of how the intervention which was delivered in the second part of the study was developed and how the ideas generated from the first part of the study were incorporated into it.

Chapter four will present the quantitative element of the study in its entirety. This part of the study involved delivering a psycho educational workshop (which was based on the themes emerging from the qualitative study) to a group of South Asian women and measuring their attitudes to help seeking before, immediately after and four weeks after the workshop. The chapter will include an introduction, methodology and results section.

Chapter five will present an overall discussion of the findings of both studies. It will also explore the clinical implications of the results, explore the limitations of the study, suggest ideas for further research and conclude the research.

Chapter six will conclude the thesis with a critical appraisal of the research focusing on the decision -making processes and the influence the research has had on the researcher.

Chapter seven will present the references and appendices to the entire study.

Chapter 2

Mental Health Help Seeking Experiences of British South Asian Women:

A Review of the Literature

2.1 Introduction

The purpose of this review is to explore the mental health help seeking experiences of British South Asian women. The first part of the review will offer a brief overview of the current literature with regards to the mental health state of South Asian women (SAW). It will then offer an overview and critique of literature which focuses specifically on the help seeking experiences of SAW and will focus on four specific themes – culture and help seeking, the influence of personal constructions on help seeking, help seeking and experiences of services and finally implications for service providers. This review will conclude by providing a summary and outline the aims and rationale of the present research study.

2.2 Search Strategy

Relevant electronic databases including PsychINFO and Web of Science were used to carry out searches including the following terms: 'South Asian women', 'British South Asian women', 'mental health', 'help-seeking', 'therapeutic help', 'cross-cultural research', 'help-seeking attitudes' and 'service provision'. Relevant articles were acquired and read by the researcher. The reference sections of these articles were also reviewed to identify further relevant articles.

2.3. An overview of current UK literature

2.3.1 The mental health status of British South Asian women

There is evidence to suggest that ethnic minorities in the UK are increasingly experiencing mental health difficulties, are over represented in secondary health services and report more negative experiences of services (Sainsbury Centre for Mental Health, 2002; Sewel, 2009 & Sproston & Nazroo, 2002). Research also suggests that

South Asian population, in particular women, have an increased risk of psychological risk and vulnerability (Fazil & Cochrane, 2003 & Sonuga-Barke & Mistry, 2000). South Asian is the term used to describe individuals whose ethnicity originates from the Indian subcontinent which includes countries such as Pakistan, Bangladesh and Sri Lanka. According to the 2011 Census, British South Asians are the largest minority group in the United Kingdom. There are various sub groups within the British Asian population (e.g.-Indian-Gujrati and Pakistani – Punjabi). They are a heterogeneous group made up of an array of traditions, languages and religions (Anand & Cochrane, 2005).

There is also growing concern that Black Minority Ethnic (BME) communities persistently under utilise services. When they do access services, they are likely to present with more severe symptoms and also terminate therapy quite early on (Abe-Kim *et al*. 2007 & Sue & Sue, 2003). A fairly recent publication by Mind (2013), which provided a briefing for clinical commissioning groups, sent out freedom of information requests to all mental health trusts in England. Results showed that Indians and Bengalis had low referral rates to crisis teams and BME groups were the most likely from all ethnic groups to be admitted to hospital once they came into contact with crisis teams. Although there is some evidence to suggest that treatment is being received by BME communities once they have been referred to crisis teams, there are barriers to the initial access of services, especially for the Indian and Pakistani community. Furthermore, South Asians, of all the different ethnic groups, are the least likely to be referred for specialist services (Bhui *et al*. 2003). There is also evidence to suggest that lack of accessible information on how mental health systems operate and the help they can offer can lead to prevention of help being sought by BME communities. Fear of the

stigma and social repercussion of seeking help and experiences of racism are some of the major barriers identified (Mind, 2013).

Acculturation refers to the process by which one culture influences another bringing about social, cultural and psychological change. Research has mainly focused on the influence of the dominant host culture on the culture of minorities such as immigrants and refugees (Gibson, 2001).

Berry (1980) proposed a model of acculturation which identifies four acculturation categories; separation (rejecting receiving culture and retaining heritage culture), assimilation (accepting receiving culture and rejecting heritage culture), integration (adopting receiving culture but also retaining heritage culture) and finally marginalization (rejecting both receiving and heritage cultures).

There is research to suggest that one possible barrier to accessing help is low levels of acculturation (Kim & Omizo, 2003 & Zhang & Dixon, 2003). Tata and Leong (1994) suggest that individuals with more traditional values would struggle to manage the stigma associated with mental health disorders as well as facing difficulties in opening up to a professional about personal problems. If we look at the acculturation categories suggested by Berry this kind of behaviour would fit into the separating category.

However, a study by Pacitti, Hughes, Statter, Alvarado-Rivero and Chaddha (2011), investigated BME communities' access of counselling services in Croydon. They found that BME communities were in actual fact accessing services in proportion to their representation in the community and were just as likely as their white counterparts to access services. Services did not need to be BME specific e.g. counsellor of same race or based in BME community organisations. However, compared to their white counterparts, BME communities placed greater emphasis on accessing services in the

voluntary sector as opposed to statutory services and on confidentiality/anonymity. There was also evidence to suggest that GP's could do more to recommend counselling services for BME communities. However, this study was limited to a small geographical area and caution must be exercised when generalising any findings on a national scale.

Various government initiatives have placed emphasis on the mental health needs of ethnic minorities in Britain and how these can be catered for, and it is not surprising then that the government has launched initiatives such as the Department of Health (2005) report "Delivering Race Equality: A framework for Action" in an attempt to address and cater for the specific mental health needs of BME communities. The

Department of Health's publication 'The Health of the Nation: A Strategy for Health in England' (1992), identified an important mental health strategy to be achieved by 2010 which was to reduce suicide rates 20%, especially amongst South Asian women who had been identified as being at high risk. There is an acknowledgement that different ethnic groups have different perceptions of mental health and different expectations of services (Department of Health, 2009). However, the 'Count me in Census' (2011), which collected data over a five-year period (2005-2010) and focuses on mental health inpatient data, highlights the fact that 22% of the 30,500 people receiving inpatient care in England or Wales in 2009, were from BME communities. This is more than the 20% admission rate in 2005. Thus, highlighting how the mental health of BME communities is deteriorating, suggesting that initiatives set out by the government, such as Delivering Race Equality Programme, appear to be failing to address the needs of BME communities.

Earlier research suggested that there was a high prevalence of depression in Asian people (Jacob *et al.* 1998 & Silveira & Shah, 1998). The majority of the time, GP's do not detect mental health distress in their Asian patients, however this could be because Asian people are less likely to report their psychological concerns to a GP (Jacob et al, 1998). South Asian Muslims in particular, are less likely than other ethnic minority groups and the general population to access mental health services (Sheikh & Furnham, 2000). A possible explanation for this is that Muslims can believe that mental illness is caused by Allah (God), and it either presents as a punishment for sins they may have committed or as a test of their faith (Al-Krenawi, Graham, & Kandah, 2000). This would explain the use of traditional healing methods or the use of prayer as a coping mechanism (Hussain & Cochrane, 2003).

The Department of Health (2002) publication 'Women's Mental Health: Into the Mainstream' also identified that Asian women face more difficulties in accessing help for their mental distress and Asian adolescent girls present with high rates of suicide, self-harm and eating disorders. Some of the identified barriers that Asians faced in accessing help include stigma associated with mental health within Asian culture, concerns about confidentiality and beliefs about causes of mental ill health (Wynaden *et al*. 2005). It is not surprising then that the mental wellbeing of South Asians is of real concern to service providers and professionals.

Research into the mental health status of British South Asian women provides some interesting albeit sometimes contradictory findings. Some of the earlier research appeared to suggest that Pakistani and Indian females had lower rates of admission to psychiatric hospitals in comparison to their white counterparts (Cochrane, 1977). However, certain methodological flaws were identified in this study including errors in reporting ethnicity and excluding certain subgroups such as Bengalis (Anand &

Cochrane, 2005). More recent research however, suggests that there are a huge number of SAW suffering with mental health problems such as depression and eating disorders (Bhugra *et al.* 2003 & Fazil & Cochrane, 2003). There is also evidence to suggest that common mental disorders are higher in South Asian women compared to other ethnic groups (Bebbington, Brugha , Coid *et al.* 2009). Neeleman, Mak and Wessley (1997) even suggest that SAW were twice as likely to commit suicide compared to their white counterparts. More recent research by Cooper *et al.* (2006) found that young South Asian women are at high risk of suicide, even if they do not have a previous psychiatric history. Husain, Waheed and Husain (2006) argue that research such as this demonstrates the extent of the problem within this community and emphasise the need for culturally sensitive services for SAW that can serve as a preventative strategy.

Research by Thompson and Bhugra (2000) suggests that South Asian women are more likely to experience stress and attempt suicide due to socio cultural factors, such as cultural conflicts and incompatibility within the family, arranged/forced marriages and lifestyle conflicts. More recent studies by Glover and Evison (2009) suggest that women from Bangladeshi, Indian, Pakistani and Black African backgrounds are less likely to engage with treatment once they have been referred to services. Findings show that barriers to recovery include inability of mental health professionals to adequately cater for the needs of participants and also negative attitudes from family members (Mental Health Foundation, 2011). In comparison to white women, South Asian women present with more mental health problems (Gater *et al.* 2009) including depression (Bhui, Bhugra, Goldberg, Sauer, & Tylee, 2004 & Gater *et al*. 2009) and anxiety (Gater *et al*. 2009 & Weich *et al*. 2004).

Earlier research by Nazroo (1997) carried out surveys with SAW and found that they had lower rates of depression and anxiety compared to their white counterparts. This was the case when they were viewed as various cultural/religious groups and as one homogenous group. Furthermore, this research also found that differences within the various cultural/religious groups existed; with Pakistani women having higher rates compared to Indian and Bangladeshi women. Nazroo also found that migrants had higher rates of depression compared to non – migrants, it could be the case that migrants would face additional barriers to help seeking (such as language). However, Nazroo acknowledged that the measures used to assess disorders in his study (Clinical Interview Schedule-Revised (CIS-R) and the Present State Examination (PSE)) were not culturally/linguistically appropriate and thus not able to appropriately translate terms into South Asian languages. This not only questions the validity of his findings, but also highlights the issue of 'category fallacy' which is a term coined by Kleinman (1987), which occurs when categories that are relevant to one culture (e.g. Western culture) are applied to other cultures (non - western) and meanings are lost or misunderstood. Despite this, there has been some other research which has supported Nazroo's findings and even suggested that Pakistani-Muslim women are most vulnerable when it comes to depression and anxiety (Creed *et.al.* 1999 & Sonuga-Barke & Mistry, 2000). This demonstrates the differences that exist within South Asians and the caution that must be used when making generalisations across the whole group. There has been little research to explore further the differences that can exist between these sub groups and the possible reasons for it.

Recent research suggests that South Asian women reportedly under - utilise available services, with suggestions that cultural and religious differences as well as language serve as barriers to treatment (Tabassum, Macaskill & Ahmad, 2000). Other barriers

include perceived stigma, shame and issues with confidentiality (Wynaden *et al*. 2005). Furthermore, referrals to mental health services are less likely (Bhui *et al*. 2003).

Despite the conflicting findings, one thing is for certain and that is that the high numbers of SAW suffering with mental health is disproportionate to the limited research that has been carried out in this area, especially with regards to interventions and help seeking (Wittchen, 2000).

2.3.2 Culture and help-seeking

With regards to trends in help seeking amongst British SAW, Gilbert, Gilbert and Sanghera (2004) carried out focus groups with SAW in Derby, and one of the strong themes to emerge was that help seeking was heavily influenced by the concept of *izzat* (honour and respect of the individual and family). This external cultural factor was seen as a barrier in accessing help. The researchers found that for a lot of South Asian women, the concept of izzat has a great part to play in determining what behaviour is deemed acceptable or unacceptable for SAW. Unfortunately, within South Asian cultures, fears of 'izzat' being compromised would mean that people would be reluctant to access help.

The concept of 'izzat' was further highlighted in more recent research carried out by Pilkington, Msetifi and Watson (2012). Their research set out to explore the factors that affect intentions to access help amongst British Muslims of South Asian origin. They wanted to measure culturally relevant variables with regards to accessing help; these included acculturation, level of religiosity, biological/social-environmental beliefs about the cause of mental health and more importantly the role of 'izzat'. Although previously qualitative studies had explored the concept of 'izzat', this was the first quantitative study to look at this factor. Ninety-four participants were recruited from

community centres and online sources. Various questionnaires were administered to measure the above variables (all in English). Results showed that high levels of education and acculturation indicated high level of intent to access help. However, 'izzat' and biological beliefs predicted lesser intent to access help. High levels of education and acculturation would fit into the separation or assimilation categories proposed by Berry (1980) thus appearing to suggest that retaining more of the host culture as opposed to the heritage culture could lead to better attitudes towards help seeking.

The collectivist nature of South Asian communities can be used as an explanation for the role of izzat in help seeking decision making. South Asians tend to be more 'allocentric', meaning that they view the self and family as one combined concept as opposed to two separate concepts. Therefore, when decisions are being made for the 'self' the impact this may have on the family is also taken into account (Das & Kemp, 1997). Al-Subaie and Alhamd (2000) also suggest that due to the fear of bringing shame to the family and the individual being seen in a negative light within the community, many Muslims will deny the existence of mental health problems. However, there is one important limitation of this study that needs to be taken into account. All the questionnaires were administered in English, meaning that the sample that was recruited would have high levels of education and high levels of acculturation; this would inevitably introduce bias into the study and potentially affect validity of results.

Research by Burr and Chapman (2004) also found that when it came to seeking help, the women they interviewed seemed to think that a visit to the GP was only legitimised if it fitted into accepted cultural norms of physical problems. Psychological problems

were not perceived as a medical problem and therefore would not warrant a visit to the GP; unless the symptoms were somatised. Further analysis revealed that SAW used their own subjective experience of their 'illness' to determine what help they felt was relevant and acceptable to them. Thus, they shaped their own help seeking experience. SAW's subjective experience was heavily influenced by the culture they belonged to. However, as most of the participants were born in the UK, it could be argued that their culture would be influenced by Western understandings of psychical and psychological symptoms and the possible confusion between the two. Discursive analysis was carried out on the data gathered from the focus groups and individual interviews. This analysis involved focusing on the linguistic content which was present. Research has shown that SAW tend to use culturally relevant discourse when describing their psychological distress (Fenton & Sadiq-Sangster, 1996), however all the interviews in this study took place in English, so it may have been possible that had the women been interviewed in their native languages a different set of discourse would emerge.

Hussain and Cochrane (2003) carried out qualitative interviews with SAW in order to explore coping strategies these women used, and what factors influenced their decision for their chosen form of treatment. The data generated in this study seemed to suggest that SAW tend to limit their help seeking to avenues which fitted in with their cultural and religious beliefs (e.g. visiting religious healers). The women tended to favour these options over more formal mental health services. This could explain why SAW are under-represented in their use of more mainstream services and would also explain research which seems to suggest that SAW tend to use culture and religion to define their mental illness. This idea of South Asians seeking help that is culturally specific is also highlighted in previous research carried out by Webb-Johnson (1995) and Aslan and Healy (1983). Furthermore, there has been some, albeit limited, evidence of

services taking on board this notion of South Asian's preferring culturally relevant help by incorporating the services offered by traditional healers with the more mainstream services offered for mental health in East London (Webb-Johnson, 1995). Research by Sheikh and Furnham (2000) into attitudes towards seeking help found that South Asians with no religious affiliations were more likely to access help from a mental health professional as opposed to those South Asians who had a stronger affiliation with a religion. This could be due to the fact that religion was not used to define and understand mental illness and thus, not a determining factor in the kind of treatment that was accessed.

Fazil and Cochrane (1998) identified certain 'cultural vulnerabilities' (social isolation, living with extended family and managing more complicated family dynamics, unhappy marriage and inter-generational conflicts) which were significantly linked with depression in Pakistani women. This fits in with previous research which has shown that differences can exist between various South Asian subgroups. (Creed *et. al.* 1999; Nazroo,1997 & Sonuga-Barke & Mistry, 2000). Thus, research which focuses on one particular subgroup, can provide a more in-depth understanding of similarities and differences of that particular subgroup in comparison to other subgroups. Fazil and Cochrane (1998) also proposed that within South Asian culture, there is a greater stigma associated with mental illness and this can explain why members of this community are hesitant to admit to mental health problems existing, and subsequently seeking help.

However, Burr (2002) argues that caution must be exercised when exploring the socio-cultural influences on the development of mental health difficulties within South Asian communities. Focusing solely on socio-cultural factors runs the risk of creating cultural stereotypes which will ultimately influence how mental illness in South Asian communities is understood and treated.

2.3.3 - Personal constructions/ definitions of mental health influencing help-seeking

Earlier enlightening research appeared to suggest that British South Asians can define symptoms of mental health differently to their white counterparts. Wilson and MacCarthy (1994) suggest that South Asian people are more likely to explain their psychological distress in terms of physical symptoms; this in turn influences help seeking patterns. Other research carried out by Gaw (1993) and Beliappa (1991) also suggests that SAW tend to 'somatise' feelings of psychological distress. Research such as this has been used in an attempt to try and explain the patterns of low levels of treated depression amongst SAW. However, research carried out by Fenton and Sadiq-Sangster (1993) found that SAW living in Bristol, were well able to understand the psychological nature of their problems and were able to appropriately put these views across when speaking in their mother tongue. Therefore, seeming to emphasise the important role language can play in SAW's experience of mental illness. The current research study set out to explore experiences of British born SAW, and for many, although English may not be their 'mother tongue', they would all be fluent English speakers; having learnt it from a young age and this is the language they would use to speak to the researcher about their experiences of help seeking. Weiss, Raguram and Channabasavanna (1995) suggest that unlike in the Western world, within Eastern cultures, there is less clear definition between somatic and psychological symptoms; there is often an overlap between the two. This may lead to difficulties SAW experience in expressing psychological difficulties and may explain why SAW tend to somatise their psychological symptoms and thus do not deem it appropriate to seek psychological help. However, research by Fenton and Sadiq- Sangster (1996) aimed to discover whether depression was seen as a Western construct. After interviewing 16 Asian women with depression, they found that the majority of the women were able to

identify the eight common symptoms of depression including loss of appetite, suicidal thoughts and sleep disturbances. These women were from a Muslim or Sikh background and none of them were British born. This research appeared to suggest that SAW were able to make the distinction between physical and psychological symptoms. Considering that there has been very little research in this area since, it is difficult to conclude whether the differences between the South Asian community's understanding and experience of mental illness and that of their white counterparts still exist. Furthermore, there is limited research which looks at British born SAW's understanding and reporting of mental illness. This kind of research would enable comparisons to be made between the understanding of British born and non - British born SAW.

More recent research by Burr and Chapman (2004) carried out discursive analysis on data generated from focus groups carried out with SAW, in order to explore the contextualisation of experiencing depression. Burr and Chapman suggest that there seems to be a strong sense of being able to cope with depression without the help of external services, and it was simply a matter of having the inner strength to overcome the depressive feelings. Therefore, depression was something that could be controlled by the person experiencing it; this may further explain the low levels of service uptake in SAW.

Helman (1990) suggests that 'explanatory models of distress' (the patients view and understanding of their illness) influence presentation of a disorder as well as patterns of help seeking in South Asian communities. Weiss, Raguram and Channabasavanna (1995) further suggest that conceptual models used to understand mental distress also influence presentation and help seeking.

2.3.4 Help seeking and experiences of services

Bowl (2007) wanted to explore the views of the South Asian community with regards to mental health services in the UK and how they can be improved. Individual interviews and focus groups were carried out and analysis of these found that low social and economical statuses had a detrimental effect on service users' mental health. However, service users also felt that their cultural needs were not acknowledged or addressed by the institutions they came in contact with.

Wright and Hutnik (2003) carried out a study as part of the Strategies for Living Programme at The Mental Health Foundation. As part of their research they re - analysed interviews carried out a few years previously to try and gain a better understanding of the strategies used by SAW to cope with their mental distress. The majority of the participants were Pakistani Muslims. Their analysis highlighted that SAW were motivated by their children to seek help. Support was also found in faith and spirituality and services catering specifically for SAW. These women also identified that fulfilling a sense of purpose through work or study helped them to improve their mental wellbeing over time. The study highlighted that probably the most crucial coping strategy for these women was having someone to talk to, whether this was a medical professional or a friend. The majority of the women described situations in which they had no one to talk to. This led the researchers to stress the importance of voluntary organisations being available that could be readily accessed by these women which offer a holistic approach in which their cultural and religious needs are incorporated. Having access to women in similar positions was also stressed as a vital factor as talking to people in their immediate social circle would bring up issues of confidentiality and stigma for these women. This is further backed by Donaghy's (1997) research with SAW suffering with depression which found that the lack of 'strong confiding relationships' increased the risk of depression developing in SAW.

A study by Netto Gaag Thanki, Bondi and Munro (2001), which explored experiences of therapy, found that Asian people who had benefitted from counselling suggested that services needed to be more publicised. Participants reported great benefits of counselling including increased confidence, self - esteem and control over life. The majority reported positive experiences of counselling; being in a safe confidential environment helped participants explore their issues, helped build confidence, have a greater sense of control over their life and develop better strategies to manage their psychological wellbeing.

A further study by the Mental Health Foundation (2011), which explored concepts of recovery and resilience in the narratives of recovering from mental distress of Black and South Asian women, found that gaining control over one's life and developing acceptance amongst other things were some of the reported benefits of recovery.

Some of the research discussed above has highlighted the need for more culturally informed services to be made available to SAW. A fairly recent study by Masood *et al.* (2015) aimed to explore the experiences British South Asian women (not all were British born) had when accessing a culturally-adapted intervention (Positive Health Programme) for post-natal depression. The rationale for their study was research which suggested British Pakistani women present with high levels of post-natal depression and experience interpersonal relationship difficulties as well as linguistic and cultural barriers in accessing help (Husain, Cruickshaw, Tomenson , Khan & Rahman, 2012). The researchers carried out in-depth interviews with 17 women who had taken part in the programme to obtain their views on the feasibility and acceptability of the intervention; bi lingual researchers were used which enabled interviews to take place in participants' preferred languages. The results showed that the main reason these

women accessed the programme was to improve well-being and self-esteem. Although some of the women faced barriers in accessing the help (mainly from family), the researchers found that if they engaged with family members, this made the process much easier for the women. Thematic analysis on the data revealed that overall all participants experienced a positive change in their attitudes and behaviours. The participants found it extremely beneficial that the facilitator of the group had the relevant training and was culturally aware and had a good understating of the social-cultural context in which participants' issue were taking place. Through the twelve week programme, participants were able to learn new coping strategies that improved their wellbeing. There are some limitations of the study however. Firstly, participants only needed to have attended four out of the twelve sessions to be classed as having 'completed' the course and secondly, no feedback was obtained from women that dropped out and did not attend any sessions. Before conclusions can be made about the 'acceptability' of the programme, it would be interesting to get the view of these participants which may affect the results obtained. Nonetheless, this study demonstrates how simple steps can be taken to make interventions more culturally informed and the potentially positive impact this can then have on the emotional wellbeing of South Asian women.

2.3.5 - Implications for service providers

A study carried out by Chew-Graham, Bashir, Chantler, Burman and Batsleer (2002) aimed to explore the link between the psychological distress experienced by SAW, and the risk of self- harm and suicide. The researchers had an overall aim of discovering good practise methods for primary care trusts and thus identify gaps in current service provisions and look at ways these could be filled. Four focus groups (n=31) were carried out with members of existing women's groups in Manchester. These groups

enabled participants to discuss their views on psychological distress within the context of their culture and individual experiences. Framework analysis highlighted particular external factors that influenced women's help seeking experiences; feared racism within help services, feared response of the wider community if help was accessed, language barriers and lack of trust in service providers. These factors played a role in women deciding not to access help. The research suggested that when unable to access the appropriate help, there was an increased possibility of women feeling isolated and distressed enough to self - harm or attempt suicide. The concept of 'izzat' as discussed previously, was also highlighted in this study as having a major influence on the lives of these women; to the point that it could pressurise them to stay silent about their problems. The women felt that the burden of 'izzat' was placed more heavily on them and resulted in high expectations from the immediate family and extended community. Some of the suggestions that these women were able to provide with regards to improving services included advertising in the right places, offering services in schools for young Asian girls, raising awareness with appropriate literature and training health visitors to provide information to young women.

However, there are certain elements of this study which make it hard to generalise any findings. Firstly, during the focus groups, the women themselves highlighted that vast differences existed within the South Asian community itself. For example, the external influences impacted different subgroups in different ways and to different extents. Therefore, this intra-group diversity makes it difficult to generalise findings across South Asians. Furthermore, the main themes were generated from discussions that took place in focus groups (for e.g. domestic violence), it could have been the case that this did not allow for other discussions or themes to be highlighted which could have also been insightful.

Bhugra and Hicks (2004) carried out a pilot study using a sample of 180 British SAW, aged between 15-75 years, to explore the effects of an educational pamphlet on attitudes for help-seeking. The pamphlet included information on recognising depression, possible coping mechanisms for depression and information on sources of help. Although it was subsequently translated into Urdu, Hindi, and Punjabi, for this study it was presented in English as all the participants were English speaking British Asians. Participants were recruited in person at GP clinics and via mail and telephone from

South Asian community organisations in London. Participants completed a self-report baseline questionnaire about attitude to help seeking and subsequent questionnaires which were completed immediately after reading the pamphlet, and then four-six weeks later. Results showed that there was a significant increase in the number of women who were willing to confide in family or professionals if they experienced depression or suicidal ideation, immediately and after four-six weeks of having read the pamphlet. There was also a 16% increase in the number of women who considered anti-depressants to be an effective treatment for depressions. The pamphlet was well received by participants and professionals and seemed to suggest that educational material can bring about some change in attitudes and perceptions towards help seeking. This is something that service providers can bear in mind when looking to increase service uptake by South Asian women. However, there are some limitations of the study which need to be taken into account before any real conclusions can be made. Firstly, validity of the results can be questioned on the basis that this was a relatively small non-random sample of participants. Furthermore, whether or not the women who took part in the study had experienced any kind of mental health or accessed any help, was not explored in the study. Therefore, participants were asked to explore their attitudes to something that they may never have experienced or may never have to do

so; how representative then are these results of SAW suffering with mental health and their help-seeking experiences?

Another study carried out by Rout and Rout (2010) explored the presence of psychological stress in South Asian Women born in Britain. In-depth, qualitative interviews were carried out with 34 SAW aged 16-29 years and analysed using thematic analysis. Results showed that psycho-social stress manifested itself in SAW in three aspects; psychological, physical and negative behaviours. By understanding how psychological stress can present in SAW it gives service providers some idea as to what support services can be developed and implemented to make help accessible and relevant for SAW.

Burr (2002) carried out focus groups and individual interviews with mental health professionals including Psychiatrists, GPs and mental health nurses to try and explore some of the cultural stereotypes held about SAW and the impact this can have on diagnosing such women and recommending treatments. The aim was to uncover beliefs and attitudes of the professionals. An inductive process of coding was implemented and any themes to do with professional's actual experience of working with SAW was separated from stereotypes and beliefs held about SAW. Analysis showed that professionals felt that external factors such as culture could be a predisposing factor for mental illness as well as influencing how mental illness presented itself. Burr found that there were various stereotypes held by the professionals regarding South Asian culture and suggested that racism existed within mental health care, but in a less obvious way. Burr used Said's idea of 'orientalism' to explain this phenomenon (Said, 1978). Said proposed that orientalism was a form of discourse and thought which portrays an 'us' (Western) and 'them' (Eastern) separation. With Western values and beliefs seen as more superior to Eastern beliefs. Burr suggests that this orientalism manifests itself

within the stereotypes held by the professionals. Eastern cultures are viewed as inferior and oppressive whereas Western cultures are seen as liberating and superior. Burr concludes that this could have a huge impact on the way in which SAW are diagnosed and offered treatment pathways; mainly by limiting what is available to SAW. However, something to bear in mind is that all four focus groups that were carried out, mainly consisted of professionals that all worked together in the same team and location. Therefore, all their experiences would be very similar, making it difficult to make any generalisations. Furthermore, by the researchers own admission, the majority of nurses who took part in this study had no direct experience of caring for SAW, so all the ideas they discussed where in a hypothetical sense. Therefore, it could be argued that if those professionals who had more direct experience of caring for SAW were interviewed, results obtained would have been very different and some of these stereotypes may have been challenged.

Hussain and Cochrane (2003) used a grounded theory approach to explore perceptions of cause and cures for depression in ten SAW (British and non-British born). All the women were diagnosed with depression. Ten women and three carers were interviewed. The women identified external factors such as marital conflict and struggles with establishing the women's role in the home as the main causes of their depression. In terms of treatment, the women used religion to not only make sense of their illness but also when deciding on what treatment to take. This latter finding in particular is interesting as it raises the question as to what role religion and spirituality play in therapy, especially when professionals are using traditional scientific evidence based interventions. Some of the limitations of the study included the fact that a diverse sample was used (in terms of ages, length of residency in Britain, religion), thus making it difficult to generalise findings. Furthermore, the views and experiences of the carer's were incorporated into the study and although these may be insightful in their own way,

to combine them with the views of the women who were actually experiencing the depression may lead to questions about the validity of the findings. Despite this, this research highlights how exploring the subjective views of South Asian and their mental health can provide insights and ideas on how interventions can be made more culturally informed. This idea of incorporating religion into the therapeutic process was also highlighted by Mind (2013) who found that when they spoke to BME communities, they found that one of the barriers to accessing help was the fear of religious needs not being met by services.

2.4 Summary of literature

Perhaps the most important factor to note about the research discussed above is how scarce the literature is on the mental health experiences, especially help seeking experiences of SAW. More importantly, there have been very few recent studies carried out in this area. Yet despite this, there is recent research to suggest that ethnic inequalities in mental health provision still remain and government initiatives such as Delivering Race Equality programme (2005) have had limited success in addressing these (Health and Social Care Information Centre, 2013). Cooper *et al*. (2013) and Cooper *et al*. (2010) have emphasised the fact that low rates of service uptake are still an issue for SAW, in particular Pakistani women who present with high levels of mental problems but low levels of service uptake (Chaudhry *et al.* 2012 & Kapadia, Louise Brooks, Nazroo & Tranmer 2015).

Studies have highlighted that needs of BME communities are not being met and various ideas have been out forward as to what can be done; it may appear however that these suggestions are not being taken on board as there is evidence suggesting mental health

needs of this community continue to be unmet and that they are extremely likely to access services when they have reached a crisis point. Once they do access therapy, they are likely to terminate it quite early on (Rugkasa & Canvin, 2011).

This review highlights some of the research carried out into South Asian women's experiences of mental health and help seeking. Emerging themes from the data include the influence of factors such as, language and culture on SAW's help seeking experience, how SAW are viewed by service providers and the impact this can have on their help-seeking. Some of the findings discussed have been used, to some extent, to explain why SAW are hesitant to seek help.

However, there does seem to be some contradictory findings in the research reported above on South Asian people in general, South Asian women specifically and their mental health experiences. Bhui and Bhugra (2001) suggest that this is a result of general methodological issues as well as those methodological issues that can present when carrying out cross-cultural research. For example, as this review has shown, language can become a barrier not only for South Asian women accessing services but also in how their symptoms are reported and interpreted by professionals involved in their care and/or researchers.

This review highlights that much of the research carried out in this area is qualitative in nature and focuses on generating themes, mainly via the use of focus groups. These broad general themes do not account for in-depth, individual subjective experiences of help seeking; experiences which cannot always be shared in group settings. The type of participants that were used in the majority of the above research can also be viewed as a major limitation. SAW who have never used mental health services or may never be likely to use them, were interviewed to generate ideas on how SAW approach help seeking. It must be taken into account that much of the research in this area has dealt

with 'treated' cases and there will be many 'untreated' cases that are not taken into account, thus bringing into question validity of any hypotheses generated (Chochrane, 1992).

There is also very little information provided about the context in which research has occurred and specific details which could impact results obtained; for example, details about the ethnicity of researchers. Researchers that come from the same background as participants may have a greater cultural understanding that could influence their interactions with participants and thus, lead to different results being obtained compared to researches from a different background.

Furthermore, it is an important thing to bear in mind that South Asians are not a homogenous group. However, researchers do not seem to take into account the differences that exist within the different subgroups of South Asians. This raises serious concerns around generalising any findings across sub groups of SAW as demographic variability based on things like religion and education etc. may mean that prevalence rates can differ across sub groups (Anand & Cochrane, 2005). Further still, research has shown that differences exist in the mental health experiences of migrant SAW and non-migrant SAW; with migrant women presenting with more difficulties than non-migrant women. (Nazroo,1997). However, the majority of the research carried out in this area does not make the distinction between these two groups nor does it focus on one group in particular, with generalisations sometimes being made across both sub groups despite research suggesting marked differences in their experiences.

2.5 – Aims and rationale for this research

The majority of the above research seems to focus on the barriers that SAW face which prevents them from accessing help. When looking at help seeking experiences in particular, the research has focused on identifying trends and patterns of help seeking and looking for possible explanations of low levels of service uptake. It seems that with regards to the research in this area; that is where the story seems to end. Fenton and Sadiq-Sangster (1996) suggest that research with BME communities focuses on incidences of mental illness between different ethnic groups, cultural factors influencing treatment of BME community and differences in routes taken by people accessing services. There is very little research on subjective descriptions and experiences of mental distress and help seeking. There is very scarce research on SAW who have experienced mental health and successfully sought help; there is little focus on carrying out research to get an in-depth understanding of their subjective experiences. This could be achieved by focusing on the types of mental health problems they experienced, the kind of help they sought, the barriers they may have faced and more importantly, how they overcame these barriers and subsequently experienced the help-seeking experience. It is hoped that carrying out research along these lines will give a better understanding of SAW's help-seeking experiences.

The Department of Health publication 'The Journey to Recovery' (2001), emphasised the potential of everyone to recover from mental distress and also empathised the important role mental health services must play in ensuring people have access to those services that will help with their recovery. A more recent strategy 'No Health without Mental Health' (Department of Health, 2011) emphasises the need for personalised services and creating greater access to services and importance of recovery. The

significance of recovery has also been highlighted by other research which has considered it more from a service user perspective and has explored concepts such as agency, empowerment and resilience; thus, more subjective experiences of recovery (May, 2005 & Repper & Perkins, 2003). Some see recovery as an ongoing process rather than an end goal (Wallcroft, 2002). However, despite this new interest in the concepts of recovery and its role in mental distress, there is limited research into the experiences of ethnic minorities and their journeys of recovery (Mental Health Foundation, 2011). This is a void in the literature that this study aims to fill.

The initial part of this research (qualitative interviews) will focus on British born SAW only. By making this distinction, it is hoped that any conclusions and hypotheses that are generated will be specifically applicable to this group; thus acknowledging the differences that can exist between the mental health experiences of migrant and non-migrant SAW. This will also open up the possibility of making comparisons between the two groups with future research. Also, by focusing on British born SAW the issue of language will also be addressed. As the research above has highlighted, language can sometimes be seen as a barrier to accessing help. However, apart from providing interpreters there is no other way of addressing this barrier at a service level. Previous research has also highlighted that language can be a barrier in how mental distress is understood and reported to professionals. Thus, by removing the language barrier out of the equation, it is hoped that this will turn the focus on other barriers that may be present and more appropriate to be addressed at a service level. This study is attempting to establish a protocol for change and although this may be limited to English speakers at this point, there is no reason that the ideas generated from the study cannot be extended to other groups (including non-English speakers) in the future.

Although there is acknowledgment of the differences that exist between sub groups of SAW, i.e. Pakistani or Indian etc, this research will not make any distinctions between these groups when collecting date for the initial part of this study. Thus, the researcher is aware of the caution that must be used when generalising any findings.

It has already been identified that one major aim of this research is to focus on how SAW overcome any barriers to successfully access help in order to provide valuable recommendations for future service provision. This emphasis on appropriate service provision also feeds into the second part of this research. This research project will not only aim to generate ideas about how SAW successfully access therapeutic help but it will go one step further and use that information to produce a psycho educational workshop to present to another group of SAW. Attitudes towards help seeking will be measured in this second group of SAW in an attempt to discover whether interventions like this can have a positive impact on attitudes towards help seeking.

Initial research on attitudes towards help-seeking explored demographic variables such as gender, race as well as previous experience with counselling (Terrell & Terrell 1984 & Leong & Zachar,1999). Research by Halgin, Weaver, Edell and Spencer (1987) indicated that having a help-seeking history is positively related to perceived positive outcomes of the process of accessing help. Further research by Terrell and Terrell (1984) and Leong and Zachar (1999), found that women and people who had previous experiencing of counselling were more likely to have positive attitudes towards help seeking. However, recent studies about attitudes toward help seeking have tended to focus on psychological and personal characteristics as opposed to demographics (Cepeda-Benito & Short, 1998; Kelly & Achter, 1995 & Komiya, Good & Sherrod, 2000).

A study by Gonzalez, Tinsley and Kreuder (2002) examined the effects of psycho educational interventions on help-seeking attitudes. Participants were required to highlight their opinions about mental ill health (Nunnally Conception of Mental Illness

Questionnaire (NCMIQ)) (Nunnally, 1961); their attitudes toward help seeking (ATSPPHS-SF; Fischer & Farina, 1995) and their expectations of therapy (Expectations About Counselling Scale-Brief Form (EAC-B)) (Tinsley, Workman, & Kass, 1980). Results showed that the participants who were given psycho educational material developed by the researchers to read did not show a significant difference in their opinions of mental distress. However, results also showed that participants who had previous experience with mental health appeared to have more positive opinions and attitudes towards help seeking. Results also indicated that a better understanding of mental health treatment resulted in a more positive hep seeking attitude.

In terms of research into attitudes towards help seeking in BME or more specifically South Asian communities, there is very scarce literature. In their study, Sheikh and Furnham (2000) found that positive attitudes were similar for British Asians, westerners and Pakistanis thus, suggesting culture is not a significant predictor of attitudes towards seeking help, even though the types of help seeking could be different. However, for the British Asian group and the Pakistani group, causal beliefs of mental distress were predictors of attitudes towards help seeking. Asians are more likely to have superstitious causal beliefs of mental health as opposed to biological causal beliefs and

the former can lead to more negative attitudes towards psychological help-seeking (Sheikh & Furnham, 2000).

This project will aim to fill the void in literature that explores attitudes to help seeking amongst South Asian women; it will aim to go beyond generating ideas about help seeking experiences and begin to look at ways in which these ideas can be used in a practical and innovative way. There is also very little research on intervention work carried out with SAW in an attempt to increase uptake of services and this project aims to fill this void. As the majority of the workshop that will be delivered will be based on the experiences of SAW who have successfully accessed help, it is hoped that this will give it more validity and credibility in the eyes of the recipients.

The UK is a multicultural/racial society, and it is inevitable that counselling psychologists will come into contact with service users from a variety of different backgrounds at some point; the question is what is the profession doing to ensure that it is ready and quipped to deal with their needs? What role does counselling psychology play in developing the understanding of experiences of minority groups and developing the right kind of treatment and interventions?

The British Psychological Society's Professional Practice Guidelines (2013) for counselling psychologists emphasises that counselling psychologists must respect the diversity and values that different clients will present with and that counselling psychologists have a duty to make themselves' knowledgeable about this diversity and review their practice accordingly. It is hoped that this research project is one way that counselling psychology research can contribute to this knowledge base and provide

insights into new and innovative interventions that can be used with marginalised communities.

To summarise, the four main aims of this study are highlighted below:

1. To fill a void in the research with regards to getting a better understanding of the experience of SAW who have successfully overcome any barriers and accessed help; with a particular focus on how they may have overcome any barriers they faced.
2. To develop an understanding of how these barriers can be overcome on not only a personal level but also at a service delivery level.
3. To use ideas generated from the interviews in a psycho - educational workshop which will be presented to a non-clinical sample of SAW and measure the impact this may have on their attitudes to help seeking.
4. To highlight and explore any implications/suggestions for mental health service providers which emerge from the data.

Chapter 3

Empirical

Research Part A

3.1 Introduction

There is a growing body of research that suggest BME communities are increasingly experiencing mental health difficulties and that mainstream health services are unable to meet the specific needs of this community (Department of Health, 2005). South Asian women in particular have low levels of service engagement with research suggesting that cultural, religious and language differences serve as barriers to accessing available treatment (Tabassum, Macaskill & Ahmad, 2000).

To recap, the four main aims of this study are highlighted below:

1. To fill a void in the research with regards to getting a better understanding of the experience of SAW who have successfully overcome any barriers and accessed help; with a particular focus on how they may have overcome any barriers they faced.
2. To develop an understanding of how these barriers can be overcome on not only a personal level but also at a service delivery level.
3. To use ideas generated from the interviews in a psycho - educational workshop which will be presented to a non-clinical sample of SAW and measure the impact this may have on their attitudes to help seeking.
4. To highlight and explore any implications/suggestions for mental health service providers which emerge from the data.

3.2 Methodology

3.2.1 Qualitative Analysis – Thematic analysis

Thematic analysis is a qualitative analytic method which is increasingly being used to analyse qualitative data. Thematic analysis not only identifies, analyses and reports data, but can also offer interpretations of the data (Boyatzis, 1998). Although some would suggest that thematic analysis is a process which is used in other more established analytic methods such as grounded theory, (Boyatzis, 1998 & Ryan & Bernard, 2000), others would argue that thematic analysis is a method in its own right (Braun & Clarke, 2006). Unlike more established methods which are more grounded in specific theoretical and epistemological positions, thematic analysis offers more flexibility, as it is seen as independent of theory and epistemology and thus, can be applied across a variety of theoretical and epistemological approaches (Braun & Clarke, 2006). With regards to epistemology in this particular study, analysis was conducted within a 'contextualist' paradigm. This is a position proposed by Braun and Clarke which they suggest sits between essentialism or realism and constructionism. Therefore, not only will this research consider the reality of help seeking for the participants and the meanings and experiences they attach to it, but it will also consider the role wider society plays in shaping and contributing to the meanings and understandings participants make about their experiences.

Thematic Analysis was the most appropriate method to use for this study mainly due to the fact that qualitative data from individual interviews would need to be analysed so that it could feed into a workshop presentation that would form the basis of the second (quantitative) part of the study. Thus, the qualitative data had to be analysed in a way which would ensure that it was generally accessible to participants in the second part of

the study. Furthermore, as previously discussed, one of the aims of this study is to identify suggestions for service providers and thematic analysis was the most efficacious way of generating ideas and themes to inform service providers.

For this study, thematic analysis was approached in an inductive way. As the study aimed to fill a void in current literature on the help seeking experiences of SAW, analysis was very much directed by the content of the entire interview data set to develop new insights. Furthermore, themes generated were at a semantic level. Therefore, there was an emphasis on the explicit meaning of the data, however in the analysis the researcher went beyond providing a description of themes and provided interpretations which can help to understand the themes on a broader level (Patton, 1990). A step by step breakdown of how the analysis was carried out can be found in section 3.2.8.

3.2.2 – Participants

Once a research proposal had been accepted by The University Of Wolverhampton School Of Applied Science student management board (Appendix A) and an ethics proposal (Appendix B), whereby ethical approval was granted by The University Of Wolverhampton Faculty of Education, Health and Wellbeing Ethics Panel, potential participant contact and recruitment took place. Further ethical considerations are addressed later in this chapter (Section 3.2.9).

3.2.3 – Sampling and recruitment

Snowball sampling was used in the recruitment of participants for this research (Goodman, 1961). This involved the researcher contacting professional individuals and organisations that may have come across potential participants and providing them with

details of the study and inclusion criteria. The researcher's contact details were provided to any potential participants that expressed an interest in taking part. These individuals/organisations were also requested to put the researcher in touch with and other professionals that may be able to help. Once participants had agreed to take part, they were also asked if they knew of anyone else that would be suitable to take part in the study. This was the most appropriate form of sampling for this study as the researcher had specific criteria that participants had to meet in order to achieve the aims of the study; they had to British born SAW aged 18-45 and they ought to have successfully accessed and completed therapy.

3.2.4 – Inclusion/exclusion criteria

There were certain inclusion criteria that had to be taken into account when recruiting participants. The first inclusion criterion was that participants had to be British born/English speaking. This was to ensure that when participants were identifying and exploring barriers to accessing therapy, language was not something that would come up as this was already a recognised and accepted barrier to help seeking (Tabassum, Macaskill & Ahmad, 2000 & Nazroo, 1997). Also, to ensure the safety of clients and to enable them to better reflect on their experiences, it was a requirement that participants had completed their therapy. Furthermore, as one of the aims of the research was to explore SAW experiences of overcoming barriers to therapy, posters and information sent out to potential participants asked for participants who had 'perceived barriers' in accessing help to come forward.

3.2.5 - Participant details

Once potential participants had contacted the investigator (MA), an informal discussion took place to determine whether they met the inclusion criteria and were willing to take part in the interviews once they had all the information. Six participants (*n*=six), were able to take part in the study; formal face-to-face interviews were then arranged. A table of participant demographics including age, ethnicity, education, marital status and how long ago help was accessed can be found in Table 1 below.

Table 1

Demographic characteristics of participants

Characteristic	*n* = 6
Age	
20-29	1
30-39	2
40-49	3
Ethnic sub group	
Indian	1
Pakistani	4
Bangaldeshi	1

Marital status	
Married	1
Single	3
Divorced	1
Separated	1
Education	
GCESs	1
A - levels	3
Graduate	1
Other	1
How long ago was counselling accessed	
6-12 months	2
2yrs+	4

A brief overview of each participant is also presented below. This includes details of why they originally accessed therapeutic help.

Participant one

Participant one was a 45year old female from an Indian background. She had accessed help as a result of experiencing domestic violence. At the time of the interview, she was working as health trainer helping people to make positive lifestyle changes. She stated that she had been feeling depressed prior to accessing help. This participant felt there

had been a real lack of support available to her; from health visitors not picking up on her symptoms to her G.P not being very helpful or resourceful when she approached him. Therapy helped this participant to deal with blaming herself for what had happened to her and to develop her confidence and self-esteem; which enabled her to move forward in her life.

Participant two

Participant two was a 21year old single female from a Pakistani background. At the time of the interview she was working as a housing support officer with women experiencing mental health difficulties as well as working with children with disabilities. She accessed help due to being in a complex and abusive relationship. She initially accessed a counselling service which was faith based but did not find this helpful and it was only when she was diagnosed with depression by her G.P that she was referred to a clinical psychologist. This participant highlighted how having psychologically aware people amongst her friends and family had a positive impact on her being able to access and stick with therapy. This participant identified lots of changes that had taken place for her following therapy; these ranged from taking more care of her physical appearance to being more socially active and being able to work and study again; two areas of her life which she was struggling with before the therapy.

Participant three

Participant three was a 38year old single female from a Pakistani background. At the time of the interview, she was living in a hostel due to being homeless. She had accessed therapy due to being abused as a child and being in a difficult marriage as an adult. Therapy helped this participant to recognise her self -worth and manage her

anxiety and panic attacks which were interfering with her daily life. This participant saw recovery as an on -going process and it was something she had to work on, on a daily basis.

Participant four

Participant four was a 41year old single female from a Bangladeshi background. She had only recently finished her counselling and had initially accessed it due to domestic violence and bereavement issues. Following the counselling and life changes she made as a result of it; she found a new sense of independence and empowerment. She recognised that there had been a lot of self - neglect over the years and that she had hit rock bottom before realising she needed to do something, Counselling was a turning point in her life and her self - esteem and confidence improved significantly as a result of it. She is currently writing a book about her experiences and working in an organisation where she is helping people who have been through similar experiences.

Participant five

Participant five was a 36year old female from a Pakistani background who was separated from her husband at the time of the interview. She had accessed therapy as a result of being in an abusive marriage and recognising she was suffering from depression. She was unemployed and was looking after her children. Therapy helped her to recognise and look after her own needs better as well as the needs of her children; overall this helped her make better choices in her life. Therapy also helped her to develop her confidence and self - esteem and learn to trust people again.

Participant six

Participant six was a 46year old married female, from a Pakistani background. She had accessed therapy after experiencing post – natal depression following the birth of her last child eight years ago. This participant reported taking a very proactive role in her recovery and throughout her journey she had not only developed her own understanding of her mental health issues but that of the people around her. Therapy has helped her to cope better with the issues she faces on a daily basis. She also saw recovery as on ongoing process and she often finds herself using the techniques she learnt during therapy.

3.2.6 – Interview development

The interview schedule was developed after a review of existing literature and identification of gaps in literature, for example the lack of research into positive experiences of therapy. The broad research question for this study was 'How do SAW successfully overcome barriers to accessing therapeutic help?' and the interview schedule explored this question by focusing on different areas including: the circumstances that led to the help being accessed, the specific (if any) barriers that were faced in accessing help (personal/contextual/environmental/cultural), the difficulties that were faced in overcoming these barriers, what helped to overcome these barriers, experiences of therapy and the impact it had had on SAW, insights/words of advice for other SAW in similar positions and also service providers. The latter two areas were important ideas to explore as the themes generated in this area would be important in forming the basis of the workshop to be presented in the second part of the study. See Appendix C for the full interview schedule.

3.2.7- Procedure

Information about the study was sent to various professionals (individual and organisations) that may have had contact with potential participants (Appendix D). Posters were also put out in appropriate local women's centres (Appendix E). Potential participants were asked to make direct contact with the researcher. Once this contact was made, an informal discussion took place in which the aims of the study were outlined and participants were given an information sheet (Appendix F). Potential participants were asked to contact the researcher if, and when they were ready to take part in the study. Six women in total contacted the researcher and a mutually convenient time and place was arranged for the interviews to take place. Before the interviews commenced, confidentiality, anonymity and consent issues were discussed and participants were asked to complete a consent form (Appendix G), and a demographic sheet (Appendix H). Participants were also told that it was the researcher's intention to publish the research. All the interviews took place in a private place and ensuring participants were comfortable enough to talk about their experiences in an in-depth way. All interviews were audio taped and transcribed with the permission of participants. Participants were provided with a thorough debrief after the interview and were also given information on local mental health services they could contact should they feel any distress, as a result of the interview (Appendix I).

3.2.8 – Data Analysis

A six phase of thematic analysis was adopted in this study as outlined by Braun and Clarke (2006). These phases are described below:

Phase one – Familiarisation with data – All the interviews were transcribed providing a verbatim account of all verbal and non-verbal utterances. The researcher then repeatedly read all the transcripts in an 'active' way in order to identify any patterns or meanings. Any initial ideas were noted at this stage. During this process the researcher was aware that the analysis was data driven in its approach and semantic themes were being identified.

Phase two - Generating initial codes - 'Coding' the data took place by systematically working through the entire data set and identifying any repeated patterns. Coding was done manually by using coloured pens to highlight the different segments of the transcripts that corresponded with the relevant code. At this stage extracts were coded more than once. Once a list of codes had been compiled, all the supporting extracts were collated with it.

Phase three - Searching for themes - This stage involved thinking about the codes in terms of fitting into broader themes. All the codes were analysed and thought was given as to how they could combine to form themes. Tables were used to collate the different codes under possible themes. Any codes that did not fit into identified themes were collated separately at this stage.

Phase four – Reviewing themes – This phase involved analysing themes and refining them. This took place by discarding any themes that did not have enough supporting data and also combing some themes as one. It was important that the themes were clearly distinguishable from each other and had adequate supporting extracts. It was also important that all the coded data fitted into the identified theme. If this 'fit' was not apparent then the theme was assessed as needing reworking or the codes were assessed as having to be discarded from the theme. Once this was done the entire data

was analysed again to ensure that the theme identified captured the meanings present in the data. Also, any additional extracts that could fit into the identified themes were also identified.

Phase five – Defining and naming themes – This phase involved clearly naming each theme and providing a brief description. Sub themes were also identified for those themes that were quite large and complex and would be better understood if they were broken down in a structured way.

Phase six – Producing a report – This phase involved writing up of the themes in a narrative that illustrated the 'story' present in the data. Relevant supporting extracts were used to enhance this illustration. A full analysis can be found in section four below.

3.2.9 – Reflexivity

The interviews were all conducted by MA who identified herself as a British born SAW from a Pakistani Muslim background; thus belonging to some of the minority groups she was interviewing. At the time, MA was a trainee counselling psychologist and identified her desire to work with people from BME communities as one of the reasons she pursued a career in counselling psychology. This desire also tied into the conceptualisation of the initial research. There was also a personal connection to the research for MA as she had a family member that had been through similar experiences as the participants. Therefore, there was a strong personal commitment to the topic of study. From the onset of the study, it was clear to MA that 'bracketing' would be extremely crucial in ensuring that her own personal experiences, emotions and preconceptions about the research area did not taint the research process in any way.

MA wrote down her feelings and preconceptions about the study right at the beginning; these were reviewed throughout the research process to ensure reduced personal bias took place. Bracketing also took place during the interviews to ensure that everything was heard and understood by MA in an open manner; semi structured interviews and open-ended questions helped with this.

Despite the personal interest in the research area, MA also researched literature in the area and found that there was a real need for more research. Due to the lack of research in the area, MA entered the interviews with an open mind and was very keen on discovering new insights. However, as the ideas generated from this study would be presented in the second part of the study, it may have been possible that during the interviews MA focused more on the questions that would generate responses that could be used in the second part of the study. For example, focusing more on tips/suggestions participants may have had as to how they overcame any barriers to help seeking as opposed to suggestions for service providers etc.

As a result of being from a similar background to the participants, MA felt that this had a positive impact on the interview process. MA felt that participants were willing to talk more 'openly' to someone who they felt could understand the cultural insights they provided. However, as MA was a trainee counselling psychologist and participants were talking about their mental health difficulties and subsequent help seeking, it was important for MA to remember throughout the whole interview process that this was not a 'therapeutic' interview and that she was present in the role of a researcher not a therapist.

3.2.10 – Ethical considerations

Participants' informed consent was obtained prior to the interviews taking place (Appendix G). Participants were assured that their data would remain anonymous throughout the research process; this was explained to them on the information sheet (Appendix F). Participants were given a pseudonym and during the transcribing of interviews, any information such as location or names that could lead to the identification of participants was edited or omitted from the transcript. As the study aimed to ask participants to reflect on experiences of accessing therapeutic help, there was a possibility that these may cause some distress for participants. To manage this potential situation, participants were advised in the information sheet that they could stop the interview at any point if they felt unable to continue (Appendix F). Furthermore, details of support organisations they could contact should they feel distressed as a result of the interview, were provided in the debrief sheet (Appendix I). In addition, the researcher (MA) and supervisor's contact details were provided should participants have any concerns or questions following the interview.

3.3 - Results

Appendix J shows a thematic map of the full set of themes and sub themes which emerged from the data, alongside supporting extracts. Each line of the transcript was numbered and participants' names were removed due to confidentiality. They will be referred as to P1/P2 etc. Ten main themes were identified and some of these (1, 2, 4, 9) contain sub themes.

1. Therapy as a positive experience

The first theme described the participants' experiences of therapy as being a positive and beneficial one. It was a complex superordinate theme which had to be split into five subordinate themes. This enabled a thorough breakdown of the different elements of the therapeutic process which had been beneficial to the participants. As the participants' all had a variety of presenting issues which led them to accessing therapy, benefits received from therapy reflected this variety however, there were some benefits that were identified across all participants.

1.1 Developing confidence and self esteem

Participants identified the building of confidence and self - esteem as an important part of the therapeutic process. Confidence was something that appeared to have been 'lost' as a result of the situation participants found themselves in, and in some cases, it was something they had struggled with developing throughout their life. Therapy helped to develop confidence and self -esteem on a personal level for the participants thus, enabling them to recognise their own value and self - worth.

A 45year old Indian woman working as a health trainer said (P1 lines 108-110)

":…because when I was coming here for counselling, it gave me that support to understand. And that taught me that, how important and valuable I am to myself so that's built me and I can see some positive outcome of these things that saying that and that is building my confidence…"

The benefits of increased levels of confidence and self - esteem went beyond this development of self - worth and began to manifest in all aspects of their life, including how they responded and interacted with the people around them.

The same participant also said (P1 lines 140-144)*: "On a personal level is that, I'm more confident and I try to now draw a, boundaries to my child which I was not doing by, before, trying to be in control by my own ten year old child because I was finding that, I have no confidence, I had lost all my self - esteem because what had happened with my ex-husband, he was always putting me down and the confidence building has helped me."*

Another woman, a 38year old single Pakistani said (P3 lines 143-145)*: "He gave me my confidence back and I found that really really you know it's good. I found that I could confide in him and talk about things about how I felt."*

1.2 Overcoming 'shame'

Participants spoke about a sense of 'shame' that they had been carrying around with them. This sense of shame that participants had internalised related to the situation they found themselves in and their experiences of psychological symptoms. This sense of shame appeared to be a hindrance in accessing help and recognising their needs. Participants identified that through the therapeutic process, they were able to explore this perception of shame and the self-blame associated with it and look at it from a different perspective. Once they were able to externalise this sense of shame, they were able to become more sympathetic to their own needs and begin the journey of catering for these.

One participant, a 38year old female said (P3 lines 200-201)*: "you've got to understand what you're going through isn't your fault and there are people out there that actually do give a damn and you can actually get help…"*

Another woman, who came from an Indian background said (P1 lines 96-97)*: "and making me understand that I'm not the wrong one, because that guilt was always there and trying to find where I'm going wrong…"*

A 21year old single Pakistani said (P 2 lines 252-255) "*:…it was sort of she didn't focus on one thing if that makes sense she sort of went deeper into into the whole issue that happened and sort of made me see it from a different perspective because in my head I was blaming myself"*

Another participant, who at the time of the interview was working with women in similar positions as herself said (P4 lines 347-353)*: "We're all in denial and it's like the shame of it, oh don't, you put, you think I'm not going to go, I'm not going to, it's not me, but do you know what it can be done.*

As one participant described, this sense of shame and associated guilt can be tied in with fears of how other people; with their inability to understand your situation, may judge you and your circumstances.

A 36year old single parent said (P5 lines 313-317): *"there is help there and it doesn't give you a bad name, it doesn't make you horrible it doesn't it's not disgraceful, you're seeking help it's like going to the doctor because you've got an illness that's not your fault, you're going there because you've got this illness and you're going to be cured."*

1.3 Recognising qualities

Therapy also helped participants to become more aware of the qualities and traits they already possessed which could be used to bring about the desired change in one's life. Therapy helped participants to recognise that by taking on board other people's perceptions and ideas about what is right and wrong or what is acceptable and unacceptable, this could make it difficult for the participant to have a clear perception on what is subjectively right for them and thus, could limit their ability to recognise their own qualities.

One participant, who had accessed help due to a difficult marriage said (P3 lines 138-143)*: "…but the counselling I did have with him he made me realise that I'm not a freak, I'm you know I'm my own person, I'm unique I'm I've got qualities about me that maybe people don't like, I'm very I'm a bit blunt. He he explained basically to me that look you shouldn't let people put you down and maybe they've got issues about the way you are and they can't accept you for who you are…"*

A 36 year old woman who was separated at the time of the interview said (P5 lines 322-326)*: "you have got other qualities recognise yourself, recognise those and go get some help, there's nothing bad in getting help and if you don't get help I mean you're just going to be stuck in that situation. God knows how long it that will last but if help is out there get it because that will make things better definitely it won't make it any worse…"*

1.4 Changing life around

All the participants focused a great deal on the visible changes they could recognise in themselves since having accessed therapy. There was a real sense of a 'transformation' that had occurred. Participants were able to talk about their life before therapy and very precisely outline the changes that had occurred within them as a result of therapy. These changes were mostly linked to their experience of psychological symptoms and participants' perception of therapy having been beneficial was linked to a reduction in symptoms they had been experiencing. From everyday things like having a wash to more difficult changes like being able to work around men, participants spoke of the life changing experiences that had occurred within them as a result of therapy.

A 21year old woman who was working as a housing officer said (P2 lines 273 – 282):

"I can I can work now, I can go back cus at the start of it when I went to her first sounds really manky I wasn't even like having a bath cus I like have a shower everyday twice a day cus I've got this ocd thing, I wasn't even having that and my personal appearance personal appearance was dead like crap and I didn't want to work I had no motivation to do anything and in my head I was just wallowing in self - pity and she sort of made me be the person that I am, like I could go out again, I still can't sleep in my bedroom and I don't think I will anytime soon and she I don't think her aim was ever to get me sleeping in my bedroom or anything it was just overcoming everything that has happened which I think I have."

Another woman, a 41year old single Bengali woman said (P4 lines 267-271)*: "Yeah, I mean within six months I saw for myself how much I'd moved on, spiritually and mentally, I had overcome things and even if I have to go over things we did, but as a person I saw myself grow from when I first stepped into the office and then six months after and I look back, and I think wow, even the professional herself turned round and said, I've seen you come on, leap and bounds, yeah…"*

The same woman also said (P4 lines 286-291)*: "So, and a way of thinking, a way of having, even talking to, even the way of actually looking after my diet, and that's, that, that, you know, that is a big thing in anyone's life, day to day relationships, my relations with my family for example, friends, social life, little things like that. Things, even down to how I unwound, relaxed, because I didn't know how to relax and my anxiety, I was, my anxiety, I mean I suffer with that from time to time, and I go through dips, and even how to handle that, how to relax as a person at home, I figured that out."*

A 46year old housewife said (P6 lines 137-146)*: "CBT was really good. It, it, I used to do some homework. They used to give me homework and that sort of helped me to see what actually panic was and why it was happening and what I could do to make it less severe on my life and I started sort of, you know when I get those intrusive thoughts, when they build up to a panic, I could like challenge them. That actually that just because it's a thought, doesn't mean it's real. And my first reaction would be like, oh panic, panic. Then, say fifteen, twenty minutes later they'd ask me if the certain things that I put into place, techniques I used to help myself, what would be my anxiety, panic*

level then? And by doing these exercises it helped, it reduced my anxiety levels, which in turn lessened my panic attacks, yeah. It really helped me."

1.4 Developing acceptance

The final sub theme identified the development of acceptance as a crucial part of the therapeutic process which helped participants' to move forward in their life. This acceptance related to the acknowledgement that they needed help as a deeper acceptance of things that had happened in participants' lives that had perhaps caused them distress.

One participant who had accessed help following domestic violence said (P4 lines 305-308)*: "certain things I can never undo, and I've started accepting that, and that, that was the biggest thing I think I realised that it's acceptance, it's very hard, I mean you're always in denial, well I can change that, but there comes a point when I thought, do you know what, you've got to accept it and move on."*

Another participant, a 21year old said (P2 lines 353-355): "*the first thing to do is to just put your mind to it and just accept that you need the help cus without the help you won't get anywhere.."*

2. Perseverance and persistence

This theme illustrated the participants' emphasis on the kind of persistence and perseverance they had needed to demonstrate in order to access help. It was split into two sub themes.

2.1 In accessing the initial help

Most of the participants' spoke about this persistence that they had to develop in making the first move to access help. Participants' acknowledged that making the first move wasn't an easy process and there were lots of factors that made taking this step difficult. Participants' spoke about developing an internal locus of control, in which they felt that they themselves were the person that had the ability and power to make that first move in accessing help. There appeared to be much internal dialogue and positive self-talk that took place for the participants developing and demonstrating this perseverance in accessing help. Furthermore, it appeared to be a solitary process in the sense that participants were alone in developing this perseverance and there did not appear to be any other people involved in this process.

<u>One participant, who had tried accessing counselling more than once said (P2 lines 202-203)</u>: *"It was just persistence, it's just your mind you've got to put your mind to it. If you don't and you let whatever it is get in the way then you're not going to get anyway."*

<u>Another woman who had experienced post-natal depression said (P6 lines 168-170)</u>: *"You see it at, through a different light and but somehow you do, you find the strength within you to carry on, knowing there are people that have overcome this and you just have to carry on really, yeah."*

However, there appeared to be cultural influence present in the sense that other people may have made the development of this perseverance difficult. There appeared to be a conflict that had to be resolved between what participants' felt was the right thing to do and what 'other' people felt the right thing to do was.

Another woman, who reported her confidence had increased following therapy said (P3 lines 223-226): *"and you shouldn't let people put you down and anyone that makes you feel like that don't allow them to do it. You've got to do something about it. You've got to."*

A 46year old housewife said (P6 lines 87-88)*: "I had that determination and let them talk what they're talking about it, I'm just going to keep on trying."*

2.2 Trying alternatives

Participants also spoke about the importance of demonstrating this persistence once the help had been sought. Participants were open to the idea that they may have to try more than one type of therapy or therapist before they found something that was able to best fit what they needed.

One woman, from a Bangladeshi background said (P4 lines 248-250): *"I had someone in between, it was an English lady in the surgery, but we didn't, her counselling just wasn't right for me, we didn't click, yet Anne's did, a few years ago, she didn't, so, everybody's different, as here I clicked with Yas you, you know."*

The same woman also said (P4 lines 436-439)*: "yeah, because sometimes that person might not be right for them, but it doesn't mean the whole organisation isn't, it just could be the one person, yes, and it all depends what that person's issues are, the actual person that goes for the help, initial help."*

3. Need to know basis

This theme described participants' experiences of limiting the amount of people they told about their help seeking and how this made the whole help seeking experience easier for them. Not having to answer to or explain to other people provided a sense of relief for participants'. Participants spoke about a lack of understanding from family and friends. One participant felt this was not necessarily a cultural issue and that people in general had a lack of understating when it came to mental health. However, three other participants made reference to their cultural background when emphasising the need to limit the number of people that knew about their decision to access therapy.

One participant, who was referred to a clinical psychologist by her G.P said (P2 lines 216- 224)*: "I think mum well didn't tell anyone, she didn't tell anyone I was I work predominantly with white people I think I'm the only Asian woman in both my jobs so obviously I started working again and it was just I told them straight up I said like I see a clinical psychologist every Monday can I have that time off work? To this day only two of my friends know because I do think-none of them know that I've been diagnosed with PTSD because I just think in order to tell them something like that I don't think they'd take it very seriously cus it's just like I don't think people take mental health seriously anyway as it is I've just not told a a lot of people to be fair."*

Another woman, a 38year old Pakistani said (P3 lines 94-97)*: "I didn't tell them. I just said I'm going out. I didn't talk about my business it's the only way you can deal with it with Asian families anyway it's the best way you-it-because I'm old enough now they don't need to know my business."*

The same woman also said (P3 lines 100-101)*: "They knew something that I was having some form of counselling but they didn't know who with, where, what and they didn't want to know and that was fine, that was easier."*

Another participant, who at the time of the interview was working with women in similar positons as herself said (P4 lines 347-353)*: "We're all in denial and it's like the shame of it, oh don't, you put, you think I'm not going to go, I'm not going to, it's not me, but do you know what it can be done. In the last three years I've done it all privately, I've been very, you know, with my, with dignity, and I did what I had to do, but nobody necessarily had to know about it, I didn't have to broadcast it, in fact I've actually directed or helped other women, say why don't you, have a bit more, so that's, so that's, I think that's helped me."*

4. Fears about being judged

This theme illustrates the fear of being judged for accessing help. It is split into two sub themes.

4.1 By members of the family or community

Almost all the participants spoke about their concerns about other people finding about them accessing help. As well as immediate family, participants were fearful of the wider community finding out about the situation and the possible shame this could bring

to them or their family. There was a sense of being judged and the stigma associated with mental health difficulties within the Asian culture was something that was at the forefront of participants minds.

One woman, a domestic violence survivor said (P1 lines 50-52): *"but being in that, in that culture I was always in the fear of people would still, and my ex-husband could pick up on me saying that I have mental health issues and my child would be taken away from me*."

Another woman, who had also been through an abusive marriage said (P2 lines 102-105): *"It was the whole sort of oh what if she finds out what if she finds out, who are we going to see at the doctors cus it's sort of like an Asian community where I live and the doctors all the Asians go there so what if they see her what are we supposed to say..."*

A 36year old woman from a Pakistani background said (P5 lines 50-51): *"It was just knowing what the community will say about me or or what perception other people would have of me."*

Another Pakistani woman said (P3 lines 39-40)*: "Well I didn't tell my family because they they just think that it's something that a weak person does, it's just a mentality…"*

However, participants were able to reflect on their perceived stigma and come to their own conclusions about what they were doing in regard to accessing help. So, although participants could recognise that this stigma existed and to some extent it made them fearful and reluctant to access the help, they were able to look past it and come to the conclusion that the problem lay with other people and not them.

The participant who was working as a health trainer said (P1 lines 76-80)*: "they'll they know people are a bit reluctant to go because they don't want nobody else to know about their situation because people are not that, I would say, everybody is not that educated to understand that there are people who, who are not even ... there, who can't read and are illiterate and they don't know."*

A participant who was currently living in a hostel said (P3 lines 83-89): *"they would be too scared or would they think a lot of people think as well I've had I've spoken to a lot of other people about counselling and their approach is basically you're backbiting, because you're talking about your problems and it's not actually allowed and it's a weakness in a person so you shouldn't really go for counselling. But I think that's a very extreme view and they need to be broad minded about their approach because they're never gonna get better that way."*

4.2 By professionals

This fear of being judged also extended to the professionals that participants would come across if they sought help. There was not only a fear of being judged on a

personal level by professionals but also the fear of professionals making stereotypical assumptions about them and in the process not fully acknowledging the issues that they may present with**.**

A 21year old woman who was diagnosed with depression said (P2 lines 112-121): *"No not really I think it was the fear of going to the doctors maybe I didn't want her to think it's another Asian girl with a sob story and stuff. So I think I had a little bit of a worry that she wouldn't take me seriously but I've known Dr Smith since I was a little child so again at the same time I was just like I guess I didn't want her to know because I was a bit embarrassed and it was a family matter at the end of the day like my dad didn't know that I had been married off my mum sort of got me married of so I was like a bit scared that she's known me for years I don't want her to judge my mum…"*

Another woman said (P5 lines 233-238): *"if you meet them outside in the street well I've never met my counsellor right but I know even if I met her it would be as if I've never seen her before and that's the fact that I really like because that actually when you're going through so many emotions that's just an added stress telling somebody and then just you know just knowing what judgement the other person is going to have about you cus you don't want people to judge you."*

5 The need for more publicising and awareness

This theme illustrates the importance of advertising and promotion of services to increase service uptake. Almost all the participants spoke about how they felt there was not enough awareness of services in the community. A couple of the participants identified this as a barrier they themselves had experienced in accessing help.

One woman, who was currently working within the local community said (P1 lines 74-75)*: "That is one of the barriers I found is having more information at community centres, more information at the places, like temples..."*

Another woman, also working within her local community said (P2 lines 296-300): *" I think people sort of it needs to be like if you I was trying to find the number for the service cus I was thinking if you Google it you can't find it it's really really hard to find and it's not broadcasted I don't think it's broadcasted enough and I don't think its advertised very well either it's really really like you can't if you're not told about it you don't know of its existence to be honest and it needs to sort of like they do an amazing job I mean they've probably helped so many people in recovery but I don't think people know that it's there…"*

Participants reported that they did not feel there was adequate promotion of services within the community. Participants spoke about the need to make information about services more accessible and readily available to SAW. There was also this idea of reaching out to SAW in their own community settings and using creative ideas such as case studies and campaigns that could help build awareness.

Participant 1 who was working as a health trainer said (P1 lines 152-154)*: "…but if there is more networking and videos can be quite helpful, people for them to have something in, some case studies that might help people to understand."*

Another woman, who had only recently stopped her counselling sessions said (P4 lines 372-382)*: "Getting more marketing I'd say, put more on the websites, go into communities where there are a lot of the South Asian women and families and children, and perhaps canvassing, perhaps campaign, doing a project. Leaflets perhaps, somewhere to go, advising women, when women go into, I mean everybody has to go to doctors, everybody has to go to hospitals, perhaps having some kind of, which they do to be fair, posters where to go, and in schools, educate, educating people in schools and colleges, where they will find that there is help. And even in shops, local, billboards, things that have, things can be done, where people go, where people go down to sit, have, supermarkets*."

Two participants also spoke about the importance of emphasising the confidential nature of services. They identified concerns around confidentiality as being a real barrier for those that may need help. If these concerns were more openly acknowledged and addressed, this could make it easier for some SAW to make the decision to seek help. This issue of confidentiality was important to SAW due to the stigma and shame associated with accessing help within their community. Both participants were conscious of the implications for their 'izzat' (honour of self or family) if people were to find out about their help seeking. Thus, they felt it was important that the confidential nature of services available was highlighted to SAW.

One participant, a 21year old from a Pakistani background said (P2 lines 324-329):

"They need to- I don't know cus you're just scared of what other people might think and it's done in a very very sort of discreet way so and people need to know that I don't think people know that, I don't think people know how discreet it is and how sort of

confidential it is and I don't think people need to worry about anything and I think that's what people need to know.."

Another participant, who identified positive changes in her life following therapy said (P5 lines 293-296)*: "Yeah I mean if they were more things about confidentiality I think a lot of the women why they don't access the services is because they don't wanna give a bad name to their family or to themselves or whatever if they know that they're not going to be labelled."*

6 Recovery as an ongoing process

This theme describes participants' experiences of recovery being an ongoing and continuous process. The majority of the participants' spoke about an awareness of the fact that there were times when their health may deteriorate and that getting it back to a stable and manageable state would take continuous effort. Some of the participants spoke about accessing help on more than one occasion; on an as and when needed basis.

One woman, who was a single parent said (P1 lines 119-121): *"…but I do go back to old way sometimes but then I come because being the counsellor knows my situation so tries to reiterate those things to me."*

Another woman, who had accessed therapy to help manage her anxiety said (P3 lines 150-152): *"Well every time I have cus I've started getting sick again now because of all the things I'm going through right now, but I've that's why I've self - referred again."*

It would appear that therapy enabled participants to become more in tune to their psychological needs and thus become more able to cater to them; whether through the help of professionals or by tapping into personal resources and new ways of coping that may have developed a as a result of therapy.

A41year old single Bengali woman said (P4 lines 334-341): *"I feel like I've gone back into some sort of remission again, but that's because there's been family upsets and what have you, but again I am handling it, because of all the experiences and all the therapy I've had, I'm now handling certain characters that I wouldn't have handled at all let's say five years ago, I'd of gone into a rage or not thought about it, but now I go home, think about it, control my complex and think about, and then say, do you know what, and I think that's because a lot of it is to do, because I've sat down and addressed me, who I was, and what I was on about from my childhood up to where I am, and so …"*

Another woman, from a Pakistani background said (P6 lines 157-161)*: "You have good days and bad days but I mean everyone's life isn't normal. They have their ups and downs so same with us. But I will, I might go through a stage when I will have a bit of a really, not a good time, but then I do get through it somehow. I've got, I'm on medication and all the things that I've learnt through the internet and in my CBT counselling, I've sort of put it all together, I take what I need when I need it."*

7 Medical professionals needing to be more proactive

This theme illustrates the participants' views on medical professional needing to be more proactive and showing more initiative when dealing with SAW that may be experiencing psychological difficulties. As the following quotes illustrate, participants felt that GP's had a crucial role to play in picking up on any psychological distress and in their experiences, this did not always happen. There was a sense that GP's were the professionals who were in a position to best advise and guide participants on what to do with regards to their health.

One woman, who felt that her G.P had not been very helpful said (P1 lines 183-186):

"I think so, GPs play a vital part in these things because as a patient, when we go there, we try to explain our situation and if these professionals signpost them to appropriate service that help they can get it at the right time and then can be that the, they can stop from further damage...."

Another participant, a 38year old single woman said (P3 lines 178-188)*: "The one thing I will say is the fact that I had to self- refer and I think there should be cases where if you go see a doctor the doctor should be able to auto-automatically you know use a bit of initiative and say look this person is obviously in a bad way and they haven't got the the guts say to to do it themselves so maybe I should refer them and ask them….the doctors did say to me that we don't want to refer you just in case you feel pushed and you don't actually turn up. But I I don't know I I still think that people need to be a bit more assertive you know people in authority they need to be a bit more assertive and and realise that this person does you know does need help and it it doesn't matter if they don't like it right now but maybe later on it will help help to them."*

Where GP's were able to pick up on some distress, their first suggestion appeared to be medication, as these quotes highlight, participants did not always feel this was the best course of action to take and this suggests that perhaps alternative options need to be explored with SAW that present in such a way as they may be open to ideas.

***<u>One woman, who had been diagnosed with depression said (P4 lines 158-160)</u>**:" ...what I said to my GP, she goes OK then, we, they give you like, they gave me about a few weeks of antidepressants, I said, I don't know if I'm going to take them, but I said, I need to be, I need to see a counsellor."*

***<u>The same woman said (P4 lines 151-153):</u>** "Well I went to my GP straightaway and, to help you they give you, straightaway they give you antidepressants to block things out, I said, but I don't want to because I live on my own and I don't want to take the risk because I've got nobody there to look after me."*

8 Developing autonomy and putting your own needs first

This theme illustrates the importance participants placed on developing their autonomy during the help seeking process. For one participant this appeared to come about as a result of internal dialogues they had in which they encouraged and motivated themselves to take the necessary steps to improve their wellbeing.

***<u>A 41year old single Bangladeshi woman said (P4 lines 127-129):</u>** "And I thought right, booked stuff with the professional, booked my counsellors, I thought right I'm going to book this, do that, and get myself, get my life back on some sort of track and get looking for work, getting ready."*

The same woman also said (P4 lines 121-123)*: "I took a vow that, that's it, it's only, what's happened, it's in the past, you can move forward and you're going to look after yourself and you're going to put yourself first."*

There was also an emphasis on taking control of the situation and being proactive enough to start making the necessary changes.

Another woman, who was a housewife at the time of the interview said (P6 lines 31-35)*: "I, I, I, I'd done, I started doing my own research on post - natal depression and things, what I could do to help myself. And there was this Asian's, Asian women's group called the AWAAZ in Wolverhampton and I went there and I, I found, found out if there was any counselling there. So that was free. So I'd done that research myself and I found that there was this lady there that I could go for counselling."*

There was an acknowledgement that not only did participants need to make the changes for their own wellbeing but also for the sake of their children and family. This appeared to be a motivational factor in wanting to get better.

Another woman, also a housewife and a single parent said (P5 lines 35-36)*: "I knew where to start and how to get help basically and I knew I had to start off with myself, look after myself and then look after the children."*

One participant described in detail the lack of support and understanding she received from her family. Instead of letting this dishearten her and put her off, it appeared that she used the fact that she was on her own in her help seeking journey to take control of the situation and make the changes she needed.

<u>One 46year old married Pakistani woman said (P6 lines 50-54)</u>*: "I, I just knew I had to get myself better because of my other children and I just started helping myself really because there was no, lots of negativity from the family. Some were saying like, she's doing it on purpose or she's gone mental or you know, like there's nothing wrong with her. There was no support whatsoever."*

<u>The same woman also said (P6 lines 91-96)</u>*: "Like just lack of, and not, lack of understanding really. Not sympathetic towards me, not, no support whatsoever. It's like I was on my own and obviously my husband was with me but it's something I had to do on my own. I went to the libraries. I, I started getting books. I went on the internet. I started studying what was happening to me. Why was I going through this? What were the things that I could do that could help me? I just went full on into the subject."*

9 Developing understanding

This theme describes the importance participants' gave to developing understanding about cultural attitudes to mental illness and help seeking. It is split into two sub themes.

9.1 Your own understanding

As the quote below illustrates, one participant had to learn to make her own distinction between what was right and wrong; what was acceptable and unacceptable. The participant spoke about the confusion that sometimes exists between what was religion and cultural and how this impacted decision making processes. As the quotes illustrate, it was only when the participant began to think about things for herself did she move

forward. Taking 'control' of the cultural influences she allowed to impact her life gave her more autonomy.

<u>One woman who had experienced domestic violence said (P5 lines 163-167)</u>*: "another thing I've noticed is mixing religion with culture, a lot of the things that you think were religious duties were actually culture so I think it was mixing faith with culture was another barrier so understanding the difference it makes you stronger…"*

<u>She also said (P5 lines 189-192):</u> *"you need to learn about your rights and what's right and wrong again to be able to overcome anything so it's just learning about it which is really difficult when you're controlled and when you've got control you know somebody's controlling over who you're meeting and who you're not…."*

9.1 The people around you

Some of the participants spoke about their experiences of trying to make their family understand what was happening to them and thus support their decision to seek help. The experience varied for participants, as this quote blow illustrates, one participant found that highlighting the fact that accessing help would make her better was enough for her family to support her decision and overcome any shame they may have previously associated with accessing help.

<u>One participant, a 38year old Pakistani woman said (P3 lines 71-74):</u> *"I just basically had to talk to them and say look I can't talk to you guys and I need someone to talk to and this is going to help me and when my mum understood it was going to help me then she was kind of o.k….."*

Another participant described a more gradual process in developing her families understanding. It would appear that for her, maintaining an open and frank dialogue with family members helped increase their understanding. There appeared to be a dual process of learning in which both the participant and the family members were gaining insight into the mental distress the participant was going through

P6 lines (199-204): *"I think, I think they should do, whatever they're going through, they should read about it and they should make their family members understand. They need to give them the information and the knowledge. Say look, this is this, I need help and I need to, you need to understand this. So they need, she needs, they need to, she needs to teach her family members that this is something that needs, I need help with. She needs to make them understand."*

This participant also highlighted the impact culture had on her families' inability to understand her emotional distress. There appeared to be this expectation of cultural conformity in the sense that she must get on with things and just learn to cope on her own because that what was expected and that was what everyone else seemed to be doing. This was deemed the most appropriate way to protect the 'izzat' of the family.

The same participant also said (P6 lines 58-62): *"Yeah, yeah. Especially like they, us being like Pakistani, the origin, they don't really understand like that people can get emotional, they don't know what emotions are. It's like you're supposed to just get on with it. Everyone else is doing it. She's got five children or she's got four*

children and well, you know, like she's coping and you just have to carry on coping, regardless of what you're feeling, yeah."

10. The first step

This theme illustrates the importance of taking that first difficult but crucial step in accessing help. Almost all participant spoke about this 'first step' on the road to recovery. Participants acknowledged that this would be extremely difficult at times but by reflecting on their own experiences, they were able to demonstrate how this first step had put them firmly on the road to recovery.

A 36year old housewife said (P5 lines 197-198)*: "It's not easy but once you do get on that ladder it keeps getting better yeah in some ways yeah it's not easy but it helps."*

Another woman said (P6 lines 194-196)*: "You want to help yourself. You want to have a happier life, more stable life. There is help out there you need to be strong and take that first step and hopefully everything will follow, yeah"*

There were strong sentiments surrounding this first step and participants made reference to 'courage' and 'empowerment'. It appeared that participants had to make use of internal resources they had to take the necessary action. Tapping into these internal resources wasn't a straight forward process however, as the quotes below illustrate, participants' had to do this alongside the demands and expectations of the people around them on what they should be doing.

P3 lines 202-204: *"you can get yourself up again but you need to make that first step and have the guts to try and you shouldn't be scared of anyone."*

Similarly, another woman said (P4 lines 7-9)*: "I'm now turning my life around to build a new chapter in my life, so I, I, I feel empowered, I took the first step, but I knew I needed the help."*

The same woman also said (P4 lines 467-471)*: "Find the courage, find the courage and make that first move, if it's something that you really, really don't want in your life and you know it's, it's destroying you, make that first move, you'll never regret it. You know consequences, there might be consequences but as long as it's not at your expense but make that first move, don't suffer in silence, a lot of women do don't they, but don't suffer in silence, get help, I'd say that."*

3.4 - Conclusion:

The qualitative part of this study set out to address the first two aims of the study; firstly to fill a void in the research with regards to getting a better understanding of the experience of SAW who have successfully overcome any barriers and accessed help; with a particular focus on how they may have overcome any barriers they faced. Secondly, to develop an understanding of how these barriers can be overcome not only at a personal level, but also at a service delivery level. Through the use of qualitative interviews and thematic analysis the following themes were generated from the data:

1. Therapy as a positive experience (five subordinate themes – developing confidence and self-esteem, overcoming shame, recognising qualities, changing life around and developing acceptance).
2. Perseverance and persistence (two subordinate themes – in accessing the initial help and trying alternatives).

3. Need to know basis.
4. Fears about being judged (two subordinate themes – by members of the family or community and by professionals).
5. The need for more publicising and awareness.
6. Recovery as an ongoing process.
7. Medical professionals needing to be more proactive.
8. Developing autonomy and putting your own needs first.
9. Developing understanding (two subordinate themes- your own understanding and the people around you).
10. The first step.

Themes one, two, three, six, eight, nine and ten were taken into the second (quantitative) part of the study and incorporated into the workshop intervention presented to participants.

3.5 Development of the workshop intervention

A new initiative co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists aims to bring together leading organisations working in mental health including the BPS. The initiative is part of the implementation of the government's mental health strategy 'No Health without Mental Health' (Department of Health 2011), which is a national policy that addresses ethnic inequalities in mental health. The report highlights issues around BME communities not getting the help they want or need, as well as issues of BME communities having difficulties in accessing primary care services amongst other things. The initiative has produced guidance for commissioners of mental health services for BME communities. In it, they advise that in order to reduce inequalities in mental health, commissioners should collect better

information about the experiences and outcomes of mental health treatments amongst BME communities. This will provide a better understanding of any specialist provisions or modification of services that need to take place. The first part of this study has provided new insights into the experiences of BME communities by exploring an under researched area; help seeking experiences of SAW with a particular focus on overcoming barriers.

The Guidelines also mention 'a scaling-up of innovations' to help improve the mental health service experience for BME communities. Furthermore, the guidelines recommend the need for greater education awareness programmes within BME communities as well as developing anti stigma and anti - discrimination campaigns. Further still, it suggests that mental health services need to take a more proactive role in encouraging and facilitating the engagement of BME service users in service involvement opportunities. Development of 'peer-led' services and 'experiential expertise' that BME service users can add to in terms of design, development and delivery of services in order to improve the mental wellbeing of the community as a whole. This report in many ways provides the rationale for the study and more specifically the intervention which was delivered. This study is an example of how the experiences of one set of service users can be presented to another group of potential service users to influence their attitudes towards help seeking in a positive way. The intervention presented in the second part of the study included extracts from the interviews carried out in the first part of the study; thus providing participants in the second part of the study access to the experiences of women who may have been in similar situations to themselves. This study has demonstrated one way of implementing 'peer led' services and more importantly has highlighted the positive impact these kind of services can have within BME communities; peer led services that are based on 'experiential expertise' which is something else that these guidelines emphasised.

This intervention was based on the principles of the theory of planned behaviour (Ajzen, 1991) which proposes that interventions can be designed to bring about a change in behaviour by targeting one of its determinants (attitudes, subjective norms or perceptions of behavioural control). In this study, the intervention was directed at attitudes based on the principle that a more favourable attitude towards a particular behaviour will lead to a stronger intention by an individual to perform the behaviour. Therefore, in this study, the overall aim was that the intervention would improve the attitude towards help seeking and this improved attitude would lead to a greater likelihood of help actually being accessed.

The intervention was in the form of a workshop and its structure was a mix of participative and didactic elements. So, although the researcher made use of a power point to guide the session and provide information, there were opportunities throughout the session for participants to share and reflect on their own and other participants' experiences; thus becoming more actively involved in the session. There were opportunities for participants to engage in group discussions throughout the session; the room was arranged so that participants were seated in a circle and this made it easy to facilitate the group discussions.

The intervention was delivered in the training room of a local children's centre. The intervention took place during school hours to make it easier for participants to attend and a crèche facility was provided by the centre for any young children. The workshop lasted for two hours.

The power point was based on some general psycho educational material and information generated from the qualitative aspect of the study. After a brief introduction and welcome to the group in which the context of the workshop was set,

agreed sharing rules were established. These included practical issues such as not talking over others but also addressed ethical issues such as confidentiality and taking time out if needed. The workshop began with some general psycho educational material (definitions of emotional/mental wellbeing, causes of mental ill health, types of mental ill health and types of support available). This information was gathered from NHS, Mind and NICE websites. The researcher ensured that the information presented in the workshop was in a simple and easy to understand manner. The researcher tried to avoid the use of too many technical terms (e.g. psychiatric problems and morbidity) and instead opted to use simpler phrases such as 'mental wellbeing' and 'emotional wellbeing' to describe mental health problems. There was also an opportunity to discuss the definition of these terms at the start of the session; this was crucial to not only set the context of the workshop but also to develop participants understanding of the subject matter especially if this was the first time they had come across these terms; psycho educational groups that aim to challenge the stigma associated with mental health accessing help, can have a positive impact on intentions to help seek. Also, the results from the qualitative part of the study had already highlighted that the stigma and shame associated with mental health problems was quite an important factor in the mental health experiences of SAW. Bearing this in mind, the researcher used phrases such as 'mental health problems can affect anyone', 'they can be very common' and 'they are not personal weaknesses'. The researcher hoped that this would help normalise the experience of mental health problems and begin to reduce the stigma associated with them. The workshop then went on to introduce participants to the research study. The researcher wanted to highlight the positive drivers emphasis underlying the overall research quite early on, so when introducing the research, used terms such as 'successfully accessed help', 'overcoming any barriers' and positive outcomes of therapy'. The workshop then went on to introduce some of the themes that

had been identified from the interview stage of the research. Each theme was presented with a brief description and a few some supporting extracts for the theme were presented to bring the theme to life for the participants. Not all the themes identified were presented due to time restraints and the fact that those themes that addressed service level issues etc. were not relevant to the participants. The selected themes included therapy as a positive experience, perseverance and persistence, need to know basis, recovery as an ongoing process, developing autonomy and putting own needs first, developing understanding and taking the first step. The full workshop presentation can be seen in Appendix N.

The researcher used her own subjective understanding to pick those themes/sub themes that would be the most powerful and inspiring to share with the participants. This subjective understanding was influenced by the researcher's past experiences in working with hard to engage client groups and experiences in delivering workshops in other job roles. The researcher's cultural intuition as to what themes would have the most impact on the women also influenced this understanding. This cultural intuition was based on the researchers own experiences of belonging to the same ethnic group as the participants. Furthermore, as the qualitative aspect of the research had highlighted, the shame and stigma associated with accessing help had been an important barrier that the SAW had to overcome, thus the researcher selected quotes from the interviews which directly challenged these barriers. Further still, the researcher wanted to share those extracts from the interviews which were the most inspiring or encouraging as well extracts which highlighted the positive changes that had come about in the participants' lives as a result of accessing the help. It was hoped that this would start to bring about the process of change for the recipients of workshop in terms of re-evaluating their attitudes towards help seeking.

and opinions. This was important as it enabled the session to become more interactive and enabled the researcher to clarify any confusion or answer any questions about the material being presented. The researcher found that this interactive element really helped in the delivery of the workshop overall. The participants felt comfortable enough to make observations and comments throughout the workshop. They seemed very keen to initiate discussion with the group on the material being presented as well as sharing their own experiences. The researcher noticed that when sharing the extracts from the interviews, there were often small smiles or small nods of the head demonstrating appreciation for the courage shown by the participants in the initial part of the study.

The workshop ended with the opportunity for participants to ask any questions and provide feedback to the workshop. No questions were asked however participants did provide some feedback. A few participants mentioned how they had enjoyed the session, found it to be beneficial and how they would be interested in attending more sessions of a similar nature.

Chapter 4

Empirical Research

Part B

4.1 Introduction

The aim of the present study is to present a psycho educational workshop to South Asian women (SAW) and measure their attitude to help seeking before, immediately after and four weeks after the workshop. The workshop will contain material from first part of the study which carried out qualitative interviews with SAW who had successfully accessed therapeutic help to get a better understanding of their experiences and how they may have overcome any barriers.

A crucial aspect of the counselling psychology profession is to be involved in the development of new ideas, knowledge and interventions which are derived from empirically based research and can lead to new ways of working that can benefit those people that may come in to contact with counselling psychologists (Woolfe *et al*. 2010). Research suggests that a high number of SAW suffer with mental health problems such as depression and eating disorders (Fazil & Cochrane, 2003) and this is in disproportion to the limited research that has been carried out in this area, especially with regards to interventions and help seeking (Wittchen, 2000).

Fischer and Turner (1970) argue that unlike other medical help, psychological help is often associated with stigma and negative attitudes. There are certain factors which influence attitudes to help seeking. For example, gender differences are significant as there is research to suggest women have more positive attitudes towards seeking help for mental health needs (Gilroy, Carroll & Murra, 2002). Furthermore, previous experience of therapeutic interventions also leads to more positive attitudes to help-seeking (Gonzalez, Alegria & Prihoda, 2005). Despite this research, very little is known about the association between attitudes towards treatment and uptake of treatment. Bhugra and Hicks (2004) stress the importance of exploring

this area further as improving attitudes could lead to an increase in accessing services and appropriate treatment.

Participation in psycho educational programs can lead to improved attitudes about people with mental illness (Corrigan & Penn, 1999 & Keane, 1990) and programs that work specifically to decrease stigma can improve those attitudes and behaviours that might be deemed as barriers to accessing mental health services (Corrigan, 2004). Further research has highlighted that those interventions that aim to reduce self-stigma and facilitate empowerment can help to improve intentions to seek help (Speer, Jackson & Peterson, 2001). Other research suggests a link between use of psychological services and attitudes towards professional help (Smith, Peck & McGovern, 2004). Although the intervention used in this study (psycho educational material in the form of a power point presentation – Appendix N) did not specifically challenge stigma, it incorporated themes that addressed issues such as self and social stigma, overcoming the shame associated with accessing help, empowerment, persistence and autonomy. Furthermore, all of these themes, had been derived from interviews conducted with SAW that had successfully accessed help. Thus, some elements of the intervention that was carried out were directly based on the words and experiences of people that the participants could relate to and identify with. The researcher was unable to find any existing research that has carried out this kind of an intervention with this client group.

4.2 Methodology

4.2.1 Attitudes Towards Seeking Professional Psychological Help Scale (ATSPPHS)

Fischer and Turner (1970) describe attitudes about seeking professional psychological help with reference to an individual's tendency to seek or resist professional help as a

result of experiencing psychological distress. Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS) was originally devised by Fischer and Turner and revised by Fischer and Farina (1995). Both versions have been in a substantial amount of research which explores psychological help seeking attitudes (Cepeda-Benito &Short, 1998; Deane &Todd, 1996; McCarthy, Pfohl & Bruno, 2010; Duncan, 2003 & Kelly & Achter, 1995). The short form of the ATSPPHS (as was used in this study) has been used more frequently than the original longer form in recent studies. The short form correlated at a coefficient of 0.87 to the original 29-item scale (Fischer &Farina, 1995). Further studies report an internal reliability of 0.87 (Cepeda-Benito & Short, 1998) and 0.75 (Duncan, 2003). There have also been various other studies which report psychometric support for the revised ATSPPH scale (Vogel *et al.* 2005; Komiya *et al.* 2000 & Constantine, 2002).

Thus, the researcher felt this shortened scale was reliable for this study and would be more practical to use as it would lighten participant burden if participants were only responding to 10 items and not 29 as in the original; especially taking into account these scales would completed at three different stages.

The revised version of the ATSPPHS is a shortened 10 item scale of the original 29 item scale (Fischer & Farina, 1995) and examines respondent's attitudes towards seeking professional psychological help (positive or negative). Items are rated on a Likert scale rating from 0 (disagree) to 3(agree); to improve internal validity of the scale, items 2, 4, 8, 9 and 10 are reverse-scored. Scores range from 0-30 with higher scores indicating a more positive attitude to help seeking compared to lower scores. (Appendix K).

4.2.2 – Participants

Once a research proposal had been accepted by The University of Wolverhampton School Of Applied Science student management board (Appendix L) and an ethical proposal (Appendix M), whereby ethical approval was granted by The University of Wolverhampton Faculty of Education, Health and Wellbeing Ethics Panel, potential participants were contacted and recruitment took place. Further ethical considerations are addressed later (Section 4.2.8).

4.2.3 – Sampling and recruitment

As was the case in the qualitative part of the study, snowball sampling was used in the recruitment of participants for this phase of the research (Goodman, 1961). The researcher contacted local women's organisations that would have come across potential participants and provided them with details of the study and inclusion criteria. The researcher's contact details were provided to any potential participants that expressed an interest in taking part. A local sure start centre contacted the researcher and expressed a great amount of interest in the research. A meeting took place between the researcher and the manager in which the manager explained that a significant number of SAW accessed the various services at the centre (mainly coffee mornings and stay and play session for their young children). The manager stated that the general consensus amongst the professionals at the centre was that the SAW that accessed the services, were at risk of mental distress. So, although they were not a clinical sample, and there was no evidence/research to back up this claim, as a result of their interactions with the SAW, the staff at the centre felt that a lot of these SAW could benefit from some sort of therapeutic input, even if it was in the form of psycho education that made them more aware of their emotional wellbeing and how to manage it. Therefore, the manager was

quite keen for the group to run at the centre. A date and time for the workshop was arranged and it was agreed that the staff at the centre would make the SAW already accessing the services aware of it and encourage them to attend. Furthermore, the researcher attended a number of the coffee mornings and stay and play sessions and had the opportunity to speak to the SAW present and provided them information on the workshop. The researcher also asked the women to invite along any other SAW that they knew who they felt may benefit from the workshop. The researcher provided information sheets for those participants that expressed an interest in attending the workshop. This was the most appropriate form of sampling for this study as the researcher had specific criteria that participants had to meet, in order to achieve the aims of the study.

4.2.4 – Inclusion/exclusion criteria

There were certain inclusion criteria that had to be taken into account when recruiting participants. As with the qualitative aspect of the study, the first inclusion criterion was that participants had to be British born/English speaking and aged between 18-45 years. This was to ensure that participants could understand the workshop as well as the questionnaires that needed to be completed. Also, has been previously discussed, this research study aimed to focus on the experiences of British born South Asian women, thus enabling any distinctions to be made between the experiences of migrant and non - migrant SAW. This inclusion criterion was clearly highlighted in all information shared with potential participants (e.g. poster and information sheet).

Also, although the poster for the research asked for SAW that had thought about accessing help or had perceived barriers in accessing help to come forward, this was not a strict inclusion criterion. Finally, to increase the validity of any findings, it was

decided that a distinction would be made between those participants that had already accessed help and those that had not. However, as it was an open workshop that was running, the researcher did not want to exclude anyone from attending the workshop and possibly benefitting from it, regardless of whether their questionnaire could be included in the data set or not. Participants were asked on the demographic form whether or not they had accessed help in the past and it was the researcher's intention to only use those questionnaires in which participants had not accessed help, thus their attitudes to possible help seeking could be more accurately measured. However, when the researcher went through the demographics sheets, all twenty -five participants had stated they had not previously accessed help thus, all the questionnaires could be used for analysis.

4.2.5 - Participant details

Once potential participants had expressed an interest in the research an informal discussion took place to determine whether they met the inclusion criteria and where willing to take part in the workshop. Participants were given information on when and where the workshop would be taking place. Twenty - five participants (n=25) were able to attend the workshop and take part in the study. Table 2 below contains a summary of participant demographics.

Table 2

Summary of participant demographics

Characteristic	**n = 25**
Age	
(21 – 25)	5
(26 – 30)	5
(31-35)	9
(36-40)	4
(41-45)	2
Ethnicity Subgroup	
Pakistani	12
Indian	7
Bangladeshi	6
Marital status	
Married	15
Single	3
Divorced	4
Separated	3
Education level	
School	7
College	8
University	10

Characteristic	**n = 25**
Have you ever felt you would benefit from therapeutic help	
Yes	9
No	16
Have you ever accessed therapeutic help?	
Yes	0
No	25

4.2.6- Procedure

Information about the study was sent to various organisations that were likely to have come in contact with potential participants (Appendix O). Posters were also put up in appropriate local women's centres in Birmingham (Appendix P). Potential participants were asked to make direct contact with the researcher. A local sure start centre contacted the researcher and agreed to support the researcher recruit participants for the research as well letting the researcher run the workshop at the centre; a date and time was agreed to run the workshop. Posters were then put up throughout the centre and the staff gave out information sheets (Appendix Q) to potential participants they came in contact with, and informed them when/where it would take place. Twenty - five women in total turned up for the workshop. Before the workshop commenced, confidentiality and consent issues were discussed and participants were asked to complete a consent form (Appendix R), and also a demographic sheet (Appendix S). They were also asked to complete the ATSPPHS questionnaire (Appendix K). The workshop took place in

the training room of the centre and lasted approximately two hours. After the workshop, participants completed the questionnaire for the second time and a thorough debrief was provided in which they were given information on local mental health services they could contact should they feel any distress as a result of the workshop (Appendix T). The researcher obtained participants contact numbers and informed them of the date and time when she would be back at the centre to meet them and complete the third and final questionnaire. It was agreed that if any participants were unable to attend that meeting, the researcher would contact them to arrange a mutually convenient time and place to have the questionnaire completed.

4.2.7 – Ethical considerations

Participants' informed consent was obtained prior to the workshop taking place (Appendix R). No identifying information was collected about participants and they were given a unique number to track their responses to the three questionnaires, this was explained to participants in the participant information sheet (Appendix Q). As the workshop aimed to get participants to reflect on their own understanding, and possible experiences of emotional and mental wellbeing, there was a possibility that these may cause some distress for participants. To deal with this, participants were advised in the information sheet that they could withdraw from the workshop or completion of questionnaires at any point if they felt unable to continue (Appendix Q). The presentation used in the workshop also identified 'agreed sharing rules' such as confidentiality and taking time out from the group if participants became distressed (Appendix N). Furthermore, details were provided in the debrief sheet (Appendix T) of local support organisations they could contact should they feel distressed as a result of the workshop. Also in the debrief sheet, contact details were provided of the researcher

and supervisor should participants have any concerns or questions following the interview.

4.2.8 – Data Analysis

The Tests of Normality table (table 3) shows that data for age, the score before, the score after and the score four weeks later are normally distributed. Therefore, tests that rely upon the assumption of normality were to be used and thus, a repeated measures Analysis of variance (ANOVA) was used for the study.

Table 3

Tests of Normality

	Kolmogorov-Smirnov[a]			**Shapiro-Wilk**		
	Statistic	**df**	**Sig**	**Statistic**	**df**	**Sig**
Age	.088	25	.200*	.973	25	.716
Before	.133	25	.200*	.944	25	.184
After	.133	25	.200*	.976	25	.799
Four weeks follow up	.115	25	.200*	.956	25	.333

4.3 – Results

Since the aim of the present study was to present a psycho educational workshop to SAW and measure their attitudes to help seeking (score) before, immediately after and four weeks after the workshop, a one-way repeated measures Analysis of variance (ANOVA) was used to investigate if there was any statistically significant difference in their attitude to help seeking (score) before, immediately after and four weeks after the workshop**.** Each of these score variables were measured in the same score data, thus we define the independent variable as score.

Firstly, when the mean scores for each state were compared by looking at the Descriptive Statistics table (table 4 below), there appeared to be a difference in scores between the three states, with means increasing at each stage. Therefore, suggesting that attitudes towards help seeking improved over the three stages.

Table 4

Descriptive statistics

	Mean	**Standard deviation**	**N**
Before	14.160	5.4900	25
After	21.320	4.6522	25
Four weeks follow up	22.240	4.6303	25

Mauchly's Test of Sphericity tests the assumption that each of the three score data are approximately equally correlated with every other score. When this assumption is violated, various corrections are applied.

The significance value is 0.043, which is less than 0.05, so the variances of the difference between levels were significantly different. Thus, the assumption of sphericity has been violated, (X^2(2)=6.293, p=0.043). As there was a violation of sphericity, corrected *F*-ratios were looked at. All of the corrected values were highly significant and so the Greenhouse-Geisser corrected values were used.

Mauchly's test indicated that the assumption of sphericity had been violated, (X^2(2)=6.293, p=0.043), thus degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity (ε = 0.250). The results showed that there was significant main effect of intervention on score variables, F (1.614, 38.730) = 229.413, p=0.000. This result suggested that score before, score after and score four weeks later were significantly different. It suggested there is a statistically significant difference in attitude to help seeking (score) before, immediately after and four weeks after the workshop; with attitudes improving.

Pair wise comparison showed that there was a statistically significant difference in attitudes to help seeking (score) before and immediately after the workshop (p=.000, M= 7.160) there was a statistically significant difference in their attitude to help seeking (score) before and four weeks after the workshop (p=.000, M= 8.080) and there was statistically significant difference in their attitude to help seeking (score) immediately after and four weeks after the workshop (p=.016, M= .920) Once again analysis indicated that attitudes to help seeking improved as time went on.

If we look back at the means we can see that attitudes towards help seeking became more positive across the three stages (Before- 14.160, After – 21.320, four weeks later – 22.240).

Chapter 5

Discussion and Clinical Implications

5.1 Introduction

The discussion examines the findings of the research in relation to the existing literature on South Asian women's (SAW) experiences of mental health and particularly the help seeking process. The discussion also highlights the limitations of the research, the clinical implications of the findings and makes suggestions for future research. The chapter will end with a conclusion of the findings of this study.

The reader is reminded of the aims of the research study:

1. To fill a void in the research with regards to getting a better understanding of the experience of SAW who have successfully overcome any barriers and accessed help; with a particular focus on how they may have overcome any barriers they faced.
2. To develop an understanding of how these barriers can be overcome on not only a personal level but also at a service delivery level.
3. To use ideas generated from the interviews in a psycho - educational workshop which will be presented to a non-clinical sample of SAW and measure the impact this may have on their attitudes to help seeking.
4. To highlight and explore any implications/suggestions for mental health service providers which emerge from the data.

5.2 Comparison with existing research

The aim of the initial part of this study was to explore SAW's help seeking experiences. Six women who had successfully accessed therapeutic help were interviewed and the data was analysed using thematic analysis. It was hoped that by interviewing SAW that had successfully sought help, a better understanding could develop of how SAW can

overcome the barriers that existing research suggests prevents them from engaging with services.

There is not a huge wealth of existing research with SAW and their mental health experiences. Research has focused in identifying the barriers that SAW in accessing help in an attempt to explain low levels of service uptake. Research by Gilbert, Gilbert and Sanghera (2004) with British SAW suggested that issues around honour and respect and the fear of being judged by the community served as a barrier for SAW in accessing help. The findings of this present study supported their research as almost all the participants spoke about the difficulties they face in managing the 'expectations' of what was acceptable and not acceptable for their immediate family as well as the wider community. This fear of bringing 'shame' on the family in the process of accessing help played heavily on the minds of participants. The concerns of the immediate family were also as a result of the families concerns about what other people would think. One participant spoke in detail about the fact that accessing help would indicate she was not coping and this was not the 'done' thing within her culture; you had to carry like everything was okay because accessing help would be seen as a sign of weakness.

Research by Burr and Chapman (2004) suggests that SAW tend to somatise psychological symptoms and that psychological symptoms alone did not always warrant a visit to the GP for SAW. However, this study found that all the participants were well able to articulate their psychological symptoms and distinguish them from physical symptoms. The majority of participants in this study considered the GP as their first port of call when experiencing their distress with the expectation that he or she would refer them to appropriate services to deal with their mental distress. Although there may have been an initial reluctance or difficulty in accessing the help, the women in this study appeared to have a good understanding of the fact that they did need some

psychological input. In fact, some of the participants also spoke about their frustrations about going to the GP and he or she not picking up on their distress, or even prescribing them medication when they themselves had thought alternative forms of treatment such as counselling would be more beneficial to them. The findings from this study lend support to research by Fenton and Sadiq (1993) which found that when speaking in their mother tongue, SAW were well able to articulate their psychological distress. As all the participants were British born/English speaking, they demonstrated this articulation. Although for some participants' English may not have been their 'mother tongue' they were all fluent English speakers from a very young age and this was established before they took part in the research. They made reference to 'depression, 'anxiety' and 'post natal depression' etc to describe their psychological difficulties. This finding also conflicts with research that suggest SAW tend to access help that is culturally specific (Hussain & Cochrane, 2003; Webb-Johnson, 1995 & Aslan & Healy, 1983). None of the participants in this research spoke about accessing or considering accessing services that were culturally specific. In fact, all of them accessed mainstream services such as counselling or psychology. Pilkington, Msetifi and Watson (2012) found that SAW born in the UK had higher levels of acculturation and were thus, more likely to access help in comparison to migrant SAW. However, their study did not look at the specific kind of help that was accessed; i.e. whether it was culturally specific or not. So the finding of this study could suggest that high levels of acculturation may mean that SAW are willing to access help that is not necessarily culturally specific, however this needs to be researched a bit more and other variables that impact help seeking taken into account before any real conclusions can be made.

Research by Wright and Hutnik (2003) found that one of the most crucial coping strategies for SAW and their mental distress was having a confidential person to speak to; whether a medical professional or a friend. This study supported this finding as

participants spoke about the benefits of speaking to a professional in a safe and secure environment; a professional who would respect their confidentiality and listen to them in a non-judgemental way. This relationship also helped participants to begin to change their perspective on their situation and develop more confidence, self-esteem, acceptance of their situation and ultimately reduce the shame they associated with accessing help. This just demonstrates the life changing experiences that can happen as a result of a meaningful connection with another person.

Research by Burr (2002) found that some mental health professionals did hold stereotypical views about SAW and this impacted how they viewed this client group in a professional context. One participant in particular spoke about her fears of being judged by professionals based on her ethnicity; she felt that she would be stereotyped and not taken seriously, and this initially made her reluctant to access help. However, once she sought help she was able to dismiss this fear and could engage with the help available.

One of the findings of the study Mind (2011) was that BME communities felt that GP's could do more to promote and suggest counselling services to them. One of the themes identified in this study was that participants felt medical professionals including GP's should be more pro-active in signposting and recommending therapeutic services to patients.

This study also lends support to a study carried out by Netto Gaag Thanki, Bondi and Munro (2001) which explored experiences of therapy in Asian people. Their results suggested that Asian people who had benefitted from counselling suggested that services needed to be more publicised, as was the case in this study. Furthermore, reported benefits of counselling including increased confidence, self esteem and developing control over life. The participants in this study also spoke about similar

benefits. Another study by Mental Health Foundation (2011) exploring concepts of recovery and resilience in Black and South Asian women, found that developing acceptance amongst other things were some of the reported benefits of recovery; this too was the case in this study.

As has been previously identified, there is a considerable lack of research with SAW who have successfully accessed therapeutic help. Therefore, this study has been insightful in the sense that it has helped explore ideas and experiences that may have not previously been addressed and by doing so it has achieved the first and second aims highlighted in section 5.1. This study has helped to get a better understanding of the benefits SAW have received as a result of therapeutic interventions. Although it can be argued that these benefits can be universally applied to anyone that has accessed help, there are some benefits that may relate specifically to SAW. For example, one of the themes that emerged was the change in perspective on 'shame'. The SAW in this study experienced 'shame' in relation to their cultural context in the sense that they felt they were going against the norm. Therapy helped them to reflect on this perspective and look at things from an alternative view. This sense of shame can be related to the concept of 'izzat' which was highlighted in research carried out by Gilbert, Gilbert and Sanghera (2004) and Pilkington, Msetifi and Watson (2012). Within South Asian communities, 'izzat' refers to the respect and honour of oneself and the wider family/community. Previous research has demonstrated how South Asian communities feel their 'izzat' is jeopardised if they access help and thus it serves as a barrier to help seeking. In this study, the women spoke about 'shame' in relation to izzat; the sense of shame they felt for accessing help when they were aware that this could have implications for themselves and their family (e.g. being discriminated against or feeling a sense of shame). These women had gone against the norm and accessed help, and it

was through therapy that they were able to challenge some of notions they held about shame/izzat and get to a stage where they could begin to see things from an alternative more healthy perspective. It could be argued that this is reflective of the assimilation category of acculturation theory as proposed by Berry (1980). There was a rejection of some aspects of the heritage culture (e.g. shame and izzat) and acceptance of the host culture in which accessing help was not as stigmatised.

There are other aspects of the therapeutic process that can be applied specially to SAW. For example, when participants spoke about the need to persevere and be persistent it could be argued that this was something SAW would need to demonstrate much more of as the stigma and barriers they faced in accessing help was greater than other communities. These included lack of understanding from family and professionals, fears of being judged and not having the appropriate awareness of how to start the help seeking process.

The second aim of the study was to identify suggestions and ideas about overcoming barriers that could be used to encourage other SAW to access help. There has been limited previous exploration of this concept. Some of the crucial themes to emerge regarding this included remaining committed and persistent with the whole process, the importance of taking that first step, only telling people on a need to know basis about the help seeking and also developing one's own and other people's understanding. Once again it could be argued that the first two points are universal ideas that could be applied to any community, and this is correct to some extent. However, the latter two suggestions were discussed by participants in relation to the specific cultural issue they

faced, i.e. fear of being judged and stigmatised and the lack of understanding that can exist within the Asian community about mental health.

Amongst all the personal accounts provided in this study, what really comes across is a sense of personal strength, resilience, and the ability to tap into internal resources that participants possessed in order to access help. It could be argued then that these are all very subjective processes and can vary from individual to individual, and thus they are traits that you either possess or do not possess. However, it could also be argued that these narratives detailing these traits can be used to inspire and motivate other people to begin developing these qualities within themselves; something which the second part of the study will explore further.

The third aim of the study was addressed in the second (quantitative) part of the study and was to explore SAW's help seeking attitudes as a result of a psycho educational workshop. Attitudes were measured at three stages; before the workshop, immediately after and four week later. Twenty-five SAW in total were able to take part in the research.

Research by Terrell and Terrell (1984) and Leong and Zachar (1996), found that women and people who had previous experience of counselling were more likely to have positive attitudes towards help seeking. This study demonstrated that women did indeed have positive attitudes towards help seeking, however it also demonstrated that people did not need to have had previous experiences of therapy in order to show positive attitudes as none of the women in the second part of the study had previous experience of therapy.

Gonzalez, Tinsley and Kreuder (2002) found that a better understanding of mental health treatment resulted in a more positive help seeking attitude. The psycho educational workshop in this study aimed to develop understanding of mental health

treatment and this in turn did appear to have a positive impact on attitudes towards help seeking, thus supporting the findings of the above research.

Previous research into the help seeking experiences of SAW has been mostly qualitative in nature and has focused on identifying barriers that may prevent SAW from accessing the help. There is very scarce research on intervention work that has been carried out with this group and the effects of this on attitudes to help seeking. This study found that the attitude towards help seeking improved significantly for the SAW immediately after the workshop and also four weeks after the workshop. This supports existing research which found that psycho educational material can improve beliefs, attitudes and behaviours towards help seeking (Corrigan, 2004 & Speer, Jackson & Peterson, 2001).

Bhugra and Hicks (2004) carried out a pilot study using a sample of 180 British SAW, aged between 15-75 years, to examine the effects of a psycho educational pamphlet on their attitudes towards help-seeking. The pamphlet was developed following focus groups being conducted with SAW. It provided information on how to recognise depression, how to treat depression, how to prevent suicide and various coping mechanisms and sources of help.

Participants completed a self-report baseline questionnaire about attitudes to help seeking, one immediately after reading the pamphlet, and then four-six weeks later. Results showed that there was a significant increase in the number of women who were willing to confide in family or professionals if they experienced depression or suicidal ideation, immediately and after four-six weeks of having read the pamphlet. The findings of this study support the study carried out by Bhugra and Hicks. Both studies found that simple interventions such as these could have a considerable impact on the attitudes towards help seeking. Existing research with SAW suggests that there are low levels of service uptake amongst this group and so it would appear that further research into interventions that could possibly improve attitudes towards accessing services

could ultimately lead to increased service uptake. It is interesting to note that the Bhugra and Hicks study was only a pilot study and is over ten years old. The fact that there has been no further research since then exploring the use of interventions highlights the need for more research in this area to promote the therapeutic intervention needs of SAW.

5.3 - Limitations of the study

There are certain limitations of the study which need to be taken into account before any conclusions are made. One reflection the researcher is able to make is that there were instances when opportunities were missed to develop a more detailed understanding of certain experiences being discussed. This could have been due to the researcher's lack of experience. Also, as the researcher had the overall aims of the study in mind and was aware that some of the information collated would feed in to the latter part of the study, more focus may have been given to certain questions over others; focus on questions that would generate ideas that would feed into the second part of the study. So for example, it may have been possible that the researcher focused more on getting an understanding of the suggestions participants had for other women in similar positions (this was relevant for the latter part of the study) as opposed to focusing on the individual life experiences which lead to participants' accessing therapy in the first place, which were also insightful in their own right. However, the researcher had to focus on addressing the aims of the present study.

Furthermore, as discussed previously, research suggests that differences can exist within sub groups of SAW and this also makes generalisations across SAW difficult. This study did not make any distinctions between SAW and they were in fact treated as one homogenous group. Also, information on the religious background of each participant was not collected. Having this information would have helped explore the differences between religious sub groups.

Factors such as the different types of help or the gender of therapists were not explored fully. In hindsight, the researcher is aware that addressing these issues more specifically, may have given some useful and interesting findings that could be explored more in relation to existing research. Or it could have been the case that exploring these issues may have given some understanding as to why and how these women were able to successfully access help.

There are also some limitations that need to be addressed for the second part of the study. Firstly, there is the fact that researcher bias may have occurred which could have affected the results of the study. All the participants were aware of the aims and objectives of the study and they were also aware that the researcher was a trainee psychologist. Thus, it may have been possible that the participants were keen to demonstrate a positive attitude towards help seeking as this was what they felt the researcher wanted. This bias could be addressed in future research in which the identity of the researcher is kept hidden and less information is provided on the aims of the study (if ethically appropriate).

The researcher also acknowledges that only twenty-five participants took part in this study. This is a relatively small number of participants and can cast some doubt on the validity of the results and how much they can be generalised. This is one of the main limitations of the study. However, this is somewhat mitigated by the consistency of the findings in that nearly all of the participants improved their ratings across testing. It was the intended aim of the researcher to recruit a much larger number of participants, but due to time restraints and difficulties in recruitment this was not possible. Further research could be carried out on a much larger scale to explore the preliminary findings of this study.

There is research that suggests that the effects of psycho education may not endure over time (Corrigan *et al*. 2002). The researcher acknowledges that the final questionnaire

was completed after a period of four weeks which is not a considerable length of time. To fully explore the long-term impact of any interventions, it would have been ideal to measure attitudes after more time had passed. Again, this was not possible due to time restraints.

5.4 - Clinical implications

The fourth aim of the study was to discover ideas and suggestions that would be beneficial for mental health services. There are certain clinical implications that have come out of this study which can be taken on board by professionals working with SAW including counselling psychologists and mental health services as a whole. The unique and innovative part of this study was that the experiences of the target population were converted into an accessible and effective intervention. It was hoped that this unique aspect of the study would give the results greater validity.

The clinical implications that have come out of this study are outlined below:

1. During the course of analysis, it became apparent that the participants stressed the importance of building greater awareness of the services available to SAW. They reflected on their own experiences to highlight the lack of information that was readily available to SAW who may be in need of such services. They felt that more work needed to be done in publicising services in creative and innovative ways amongst SAW.
2. Secondly, the confidential nature of services was something that a few participants felt needed to be highlighted more. These participants identified that fears around confidentiality would be seen as a barrier to help seeking for many SAW and thus, they felt acknowledging and talking about this more openly when advertising services would help more SAW to access help. This is

something that could be addressed quite easily and practically by service providers when advertising services for SAW (e.g. highlighting this point on flyers or referral forms etc).

3. Another theme to emerge from the data was this idea that professionals that came in contact with SAW that may be experiencing distress, especially GP's, needed to be more pro-active in their approach. The SAW in this study felt that these professionals should be more assertive in recognising and responding to the mental health needs of SAW.
4. A fourth clinical implication is that although for SAW the cultural context in which their problems may be occurring is of importance; from the barriers they may face being due to cultural reasons (such as concepts of 'izzat' or lack of understanding of mental health) or even the way in which they may make sense of their situation, there is a need for professionals to acknowledge this cultural influence but also be able to look beyond it and not fall into the trap of making stereotypical judgements or assumptions about SAW. Professionals could benefit from having access to information booklets or training to develop their understanding on culturally specific concepts such as 'izzat'. This study found that despite the cultural influence, there was a lot more to the story of SAW during the course of therapy. Therefore, it is important that professionals are able to acknowledge and respond to the subjective needs and experiences of each SAW they may encounter, as an individual and not just as a member of a particular culture.

5. There is some research to suggest that South Asian cultures are more likely to focus on approaches that emphasise acceptance of mental ill health (Abudabbeh & Hays, 2006). One of the themes that this study also identified was that of

developing acceptance. It could be thus suggested that counselling psychologists working with this client groups could make greater use of approaches that focus on acceptance including mindfulness (Segal, Williams & Teasdale, 2002) and acceptance and commitment therapies (Hayes & Wilson, 2003).

6. There is also research that suggests that normalising help seeking behaviours and promoting the effects of therapy can help improve attitudes to help seeking (Shin & Lukens, 2002); this study has also demonstrated this. Counselling psychologists can use this insight to play a pivotal role in developing and delivering psycho education detailing the effects of therapy to marginalised groups.

Results also indicated that a better understanding of mental health treatment resulted in a more positive help seeking attitude. This would suggest that developing understanding of the mental health treatment process, could improve attitudes towards help seeking. This understanding could be developed by making information about the process more accessible and normalising the whole help seeking process. The use of the intervention in this study is an effective way of normalising the help seeking process. The power point presentation is a quick, cost effective, practical intervention that can be delivered in a range of settings to target populations. Theses settings could include schools, work places, places of worships and community centres etc. The unique aspect of the intervention would always be maintained (e.g. sharing experiences of participants that the target population can relate to) but the power point format is flexible enough to be adapted to suit the needs of target groups.

This could include things like linguistic factors or practical factors like duration of sessions etc.

7. This study has to some extent addressed some of the suggestions put forward by the new initiative co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists as part of the implementation of the government's mental health strategy 'No Health without Mental Health' (Department of Health 2011), which is discussed in more detail in Section 3.5. It has generated new insights into the mental health treatment experiences of South Asian women and used these to identify some ideas for service provision for this client group in the future. The ideas generated in this study can be used to further develop similar peer led services, not only for SAW but for other parts of the BME community; thus helping to address government concerns about inequalities in mental health services as outlined in the above strategy. This demonstrates the key role counselling psychologists can play in the development of new research which can address health concerns at a national level. It is the uniqueness of the intervention (being based on the experiences of other SAW) and its positive impact on attitudes towards help seeking that sets it apart from other peer led services and has the potential to be able to address national health concerns.

8. Finally, this study has demonstrated how a new and innovative intervention can be used to improve attitudes towards help seeking. Counselling psychologists can use the knowledge gained from this study to think about how similar interventions can be developed and used with other marginalized or hard to engage groups to try and improve their attitudes towards help seeking. This

highlights the flexibility of the intervention developed in this study; it is an intervention that can be quite easily adapted or adjusted to meet a whole range of needs.

5.5 - Further research

During the process of analysis, the researcher became aware of the full richness of the data. Each participant presented with a detailed account of their journey though therapy. This journey could clearly be mapped out with a beginning, middle and end. At this point the researcher felt that perhaps thematic analysis would not fully capture the essence of the story that was being told. The researcher looked into other methods of analysis, specifically narrative analysis which would capture the sense of continuity in the story being told (Murray, 2003 & Riessman, 1993) and explored the option of using this method of analysis or doing an analysis with both methods. However, due to the overall aims of the study and the link between both parts of the study, it was important that data was analysed in such a way that it could be made accessible to participants in the second part, thus thematic analysis was the best method for this study. The researcher strongly feels that carrying out similar research with different methods of analysis would produce detailed and insightful ideas about SAW and their help seeking as well as their experiences of therapy.

This study highlighted that cultural influences do play a role in SAW's experience of mental distress and subsequent help seeking. However, there can be other factors that impact this process such as sociological, economical or physical factors and it may be beneficial to carry out research exploring these ideas to get a fuller understanding of SAW and their experiences of help seeking.

Also, as has been previously acknowledged, this study did not explore in great detail the specifics of the therapeutic process, i.e. gender of therapist or the specific type of

therapy used etc. This was mainly due to the fact that one of the aims of this study was to test the efficacy of a peer-led intervention and this determined the focus of the qualitative aspect of the study. However, further research could still be carried out with SAW who have successfully accessed help which explores these details in more depth; this may help develop themes that can be used to inform service provision.

Finally, more innovative intervention work needs to be carried out with SAW to get a better understanding of how service can adapted to not only become more accessible to them but to be able to cater to their specific needs. The second part of this study aimed to carry out one such intervention with a group of SAW to explore their attitudes to help seeking and start looking at ways in which these can be improved.

Although the second part of this study explored the impact of psycho educational material on willingness/attitudes to help seeking it did not look at the influence of other factors such as stigma on attitudes to help seeking. This was due to the emphasis of this study being on positive drivers in accessing therapy as opposed to negative barriers. However, further research could still be carried out that measures variables such as stigma before and after this kind of an intervention to explore any difference that might occur. As Sheikh and Furnham (2000) suggest, there is very limited research on the link between beliefs about mental health and subsequent help seeking attitudes and behaviours in SAW.

Also, attitudes to help seeking can be quiet a deep rooted phenomena to attempt to change. Attitudes are developed over a number of years and influenced by a huge range of factors. Thus, it would be naive to suggest that a simple intervention like this on its own would be enough to completely shift attitudes permanently. It may be the case that

more in depth work needs to be carried out on a more longitudinal basis to explore any shifts that can occur in attitudes or beliefs about help seeking that are more ingrained. Furthermore, the researcher initially aimed to only recruit participants that may have been reluctant or hesitant to access help (they may have been advised to by a professional), practically this was a difficult inclusion criteria to stick with. Further research could be targeted at those people that demonstrate reluctance in accessing help to get a better understating of the kind of results that can be achieved with this kind of an intervention with more hard to engage (for therapy) participants.

5.6 – Conclusion

This study has demonstrated how qualitative interviews can be used to gather rich and detailed information about the help seeking experiences of British born South Asian women. It has not only helped to get a better understanding of their experiences but identified ideas which can be used to provide services in the future. This study has also demonstrated how such information can be used to develop new and innovative interventions that can be used with a client group that appear to have low levels of engagement with and referral to mental health services. It is hoped that this study will begin the process of thinking about how such interventions can be developed further and not only used with this client group but also other marginalised groups and the role that counselling psychologists can play in this.

Chapter 6

Reflective

Critical appraisal

6.1 Introduction

My research thesis included a literature review of the mental health status and help seeing experiences of British South Asian women (SAW), a qualitative study exploring the experiences of women who had successfully accessed therapeutic help and a quantitative study which explored the impact of a psycho educational workshop (based on themes derived from the qualitative study) on the help seeking attitudes of another group of SAW. The aim of this critical appraisal is to reflect on the whole experience of carrying out this research. It will reflect on the initial conceptualisation of the research idea, the processes involved in the decisions made throughout the research process, reflections on actually carrying out the research and finally, reflections on how I have been influenced and developed in a professional capacity as a result of the research.

6.2 Choosing the research area

I have always had an interest in mental health experiences of the BME community and in particular the South Asian community. Being South Asian myself, and having had family members that have experienced mental distress, I was aware from a young age the difficulties that sometimes existed for this community with getting the help that they needed. When I look back at my decision to pursue a career in counselling psychology, I can say that one of the motivating factors was that I wanted to be in a position where I could help people from this community in managing and overcoming their mental

distress. I was aware through my own experiences the difficulties that existed in terms of language barriers and cultural differences that prevented members of this community in accessing help. I felt that because I came from a similar cultural background, I was in a good position to be able to address these barriers. Therefore, when it came to thinking about ideas for my thesis, carrying out research with the South Asian community was at the forefront of mind; however, I did explore other possibilities such as how people use their spirituality to make sense of their mental distress. When I looked into existing literature and discovered there was a real lack of research within the South Asian community experiencing mental distress, I knew this would be the study for me. I narrowed my research down to South Asian women in particular and this was again after reviewing the literature and discovering that there was a high prevalence of mental distress in South Asian women with research suggesting low levels of service uptake (Tabassum, Macaskill & Ahmad, 2000). Furthermore, coming from this cultural background made me aware that it was sometimes easier being a female in order to get access to this client group. Alongside the personal commitment and interest I had in carrying out research with this client group, I was also very keen on developing any kind of clinical knowledge that could be used in not only my practice as a counselling psychologist but in the profession as a whole. For me it was pretty simple; the literature appeared to suggest that SAW faced barriers in accessing help and in order to start thinking about how SAW can overcome these barriers, what better way than to speak to SAW that had successfully done this.

6.3 Ethnicity

The fact that I belonged to the same ethnic background as the participants I would be interviewing was something I had to reflect on throughout the whole research process. I have already discussed how belonging to this community played an important role in

deciding on my research area. When I started recruiting participants I was aware that two things could happen; participants would be more willing to open up to me as they would feel I came from a similar background and thus, I could understand the cultural context in which their problems occurred, or that participants would be more weary of talking to me as they felt I belonged to the same community as them and they would be worried about issues to do with confidentiality etc. What I actually found was that both these things happened. So although there was an added advantage of belonging to the same community, I felt there was also a great resistance to engagement in the study that I had to deal with. However, I did find that once participants had been fully briefed on the study and their concerns around confidentiality had been addressed, they were willing to open up and share their experiences. When I reflect on the dynamics that existed between myself and participants during the interviews I feel that I was able to connect with them at an in-depth level; I feel there was a shared understanding present (based on cultural factors) which had a positive impact on the interview process.

6.4 Deciding on a mixed methods approach

In the early stages of my research I was pretty adamant that I would only do a qualitative research project. This was mainly to do with my fear of statistics. I just did not feel that I had a good enough grasp of statistics to incorporate it into my study. I was initially only going to explore the help seeking experiences of South Asian women and try and get as much understanding of this as I could. However, a conversation with a lecturer about how it would be a good idea to do some kind of intervention work with this client group made me think outside the box a bit more. That is when I thought it would be a good idea to try and do something which could possibly improve attitudes to help seeking. Initially I thought I would do this as two separate studies, but then the idea of having the results of one study feeding directly into the other study came about. On one hand I was extremely excited about a research idea which I thought was quite

unique and had a lot to offer the profession; I was excited of the thought of not only carrying out research to generate new ideas but then to be able to implement this ideas in a practical way, something which I felt was at the core of the kind of way I wanted to practice as a counselling psychologist. On the other hand, I struggled with the anxiety I experienced regarding statistics and this anxiety followed me throughout the research process. However, it was the thought that I could possibly produce some findings that could be of relevance to mental health professionals working with South Asian women and perhaps get them thinking about how the low levels of service uptake could be dealt with that kept me motivated in facing my fears of statistics and carry out a mixed methods study. In hindsight, I now have a greater appreciation of what a mixed methods study can offer my profession; not only is there an opportunity to carry out objective scientific research but to combine this with research which is more reflective and subjective in nature.

Deciding on what kind of qualitative analysis to do was quite straightforward. I needed to be able to use the results in the second part of the study and thematic analysis seemed the best way to make the results most accessible and presentable to the second group of participants. There can be sometimes be some ambiguity in doing thematic analysis so it was important for me that I had a structured approach to the analysis; one which I could use to guide my work. After some exploration, I came across Braune and Clarke's (2006) approach and this made the most sense to me. It was clear and simple enough to follow yet I felt it gave me enough scope to examine the data in an in depth and critical way.

6.5 Reflections on the research journey

When I think back on my research journey, the best way I would describes it is a state of mixed emotions and thought processes. I recall the excitement, enthusiasm and focus, especially in the earlier days, and I also recall the stress, anxiety, self-doubt and

moments of sheer panic. Some parts of the research process were more straight forward and enjoyable than others. I remember I particularly struggled with recruitment; especially for the qualitative part of the study. I recall contacting numerous organisations working with South Asian women in an attempt to recruit, but more often than not found that my attempts were fruitless. It was quite frustrating when I wouldn't get a response or when people appeared unwilling to help. What added to the frustration was that some of these organisations were especially set up to work with women from this particular background in an attempt to improve access to services, yet here I was trying to carry out research that could add insight to this area yet very few people appeared willing to help. There also came a point when I started to question whether the kind of participants I wanted to recruit actually existed; maybe there weren't any SAW that had positive experiences of therapy. Having these doubts and questioning the rationale of my research at this point was not a healthy state of mind to be in and I think this was probably one of the hardest points for me to deal with throughout the research process. However, once I recruited one participant, things started to flow a lot better and I managed to recruit six participants. Interviewing these women was a very special moment for me and one of the highlights of the research; it affected me both on a personal and professional level. When I got to sit with these women and hear their stories, I felt connected with their stories and I felt honoured that they were sharing them with me. I couldn't help but feel proud as they told me about how they had overcome all the obstacles in their way and managed to turn their life around. Based on the experiences of my own family members that had experienced mental distress, I felt I was able to relate to these women and empathise with them on a very personal level. At the same time, I felt a huge amount of responsibility; I realised that this was the first time some of these women had shared their experiences with

someone other than their therapist. I felt that what they were sharing with me was so valuable and insightful, I needed to do justice in how I handled and presented this information. It was times likes this I was really able to connect with my research and think of the value it could have for my profession.

I really enjoyed the second part of the research where I delivered the workshop to a group of SAW. I had been delivering workshops in my clinical practice for some time and it felt quite natural and comfortable for me to deliver the workshop. However, there was an extra connection with the workshop as it was based on data I had collected. Thus, I was conscious of my role as a researcher in that setting; I was conscious of the fact that I was presented new and valuable information which could be of great benefit to these women. The sense of responsibility I felt in ensuring that I accurately illustrated the stories and accounts I had come across in the interviews was paramount throughout this whole process.

6.6 Research and my clinical practice

I feel that some of the data generated from this research can not only benefit my own clinical practice but that of the profession as a whole. It has been satisfying to think that during this research process I have been able to identify and explore new ideas with regards to improving the help seeking experiences of a hard to engage marginalised group. I think this demonstrates the important contribution that counselling psychology can offer in the development of new ways of working which are grounded in empirical research and can inform the profession as a whole. I feel that this research has demonstrated how counselling psychologists can combine both objective scientific approaches with more subjective reflective approaches to inform their practice.

6.7 Conclusion

At some point in the future I intend to submit a journal based on this research for publication. I feel that it is crucial that the stories I have uncovered should be heard on a wider scale. As I have discussed, I had a strong personal commitment to carry out research in this area, however I also relished the opportunity to carry out research in an area that I felt needed further development. Carrying out this research helped me develop my role as a scientific- practitioner because it has enabled me to implement phenomenological ways of thinking, practising and making enquiry whilst holding onto the scientific foundations of traditional psychology.

Completing this research has not been an easy process, it has pushed and challenged me in ways that I wasn't expecting and has impacted me both on a personal and professional level. What has kept me motivate throughout the whole process is the determination to generate new ideas and knowledge that influence not only my own practice with this particular client group but to also influence the psychology profession as a whole.

Chapter 7

References and

Appendices

References

Abe-Kim, J., Takeuchi, D.T., Hong, S., Zane, N., Sue, S. & Spencer, M.S. (2007) Use of mental health-related services among immigrant and US-born Asian Americans: Results from the National Latino and Asian American Study. *American Journal of Public Health,* 97, 1–8.

Abudabbeh, N. & Hays, P. (2006). Cognitive-behavioural therapy with people of Arab heritage. In Hays, P.A., & Iwamasa, G.Y. *Culturally responsive cognitive-behavioural therapy: Assessment, practice, and supervision.* Washington, DC: American Psychological Association.

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes,* 50(2), 179-211.

Al-Krenawi, A., Graham, J.R. & Kandah, J. (2000). Gender utilization of mental health services in Jordan. *Community Mental Health Journal,* 36, 501–511.

Al-Subaie, A. & Alhamad, A. (2000). *Psychiatry in Saudi Arabia. Al- Junun: Mental illness in the Islamic world.* Madison, WI: International Universities Press.

Anand, A.S. & Chocrane, R. (2005) The mental health status of South Asian women in Britain. *Psychology & Developing Societies,* 17, 195-214.

Aslan, M. & Healey, M. (1983) Asiatic medicine. *Update,* 27(8), 1043-1048.

Bebbington, P., Brugha, T. & Coid, J. (2009). *Adult psychiatric morbidity in England 2007.* London: NHS Information Centre.

Beliappa, J. (1991) *Illness or Distress? Alternative models of Mental Health.* London: Confederation of Indian Organisations.

Berry J.W. (1980) Acculturation as varieties of adaptation. In Padilla A.M. *Acculturation: Theory, models, and some new findings,* 9-25. Boulder, CO: Westview.

Bhui, K. & Bhugra, D. (2001) Transcultural psychiatry: Some social and epidemiological research issues. *International Journal of Social Psychiatry.* 47(3), 1-9.

Bhui, K., Bhugra, D., Goldberg, D., Sauer, J. & Tylee, A. (2004). Assessing the prevalence of depression in Punjabi and English primary care attenders: The role of culture, physical illness and somatic symptoms. *Transcultural Psychiatry*, 41(3), 307–322.

Bhui, K. (2003) Ethnic variations in pathways to and use of specialist mental health services in the UK: systematic review. *British Journal of Psychiatry,* 182, 105–106.

Bhugra, D. & Hicks, MH. (2004) Effect of an educational pamphlet on Help-seeking attitudes for Depression Among British South Asian Women. *Psychiatry online*, 55(7) 827-29.

Bowl, R. (2007) The Need for Change in UK Mental Health Services: South Asian Service Users' Views. *Ethnicity & Health,* 12(1) 1-19.

Boyatzis, R. E. (1998) *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

British Psychological Society (2013) *Professional Practice Guidelines*. London: BPS. Retrieved 15 May 2016, from http://www.bps.org.uk/sites/default/files/documents/professionalpracticeguidelines-divisionofcounsellingpsychology.pdf.

Burr, J. (2002) Cultural stereotypes of women from South Asian communities: mental health care professionals' explanations for patterns of suicide and depression. *Social Science & Medicine*, 55, 835-845.

Burr, J. & Chapman, T. (2004) Contextualising experiences of depression in women from South Asian communities: a discursive approach. *Sociology of Health & Illness,* 26(4), 433-452.

Census 2011: National Report for England and Wales. London: The Stationary Office.

Cepeda-Benito, A. & Short, P. (1998). Self-concealment, avoidance of psychological services, and perceived likelihood of seeking professional help. *Journal of Counselling Psychology, 45*(1), 58-64.

Chaudhry N., Husain N., Tomenson B. & Creed F. (2012) A prospective study of social difficulties, acculturation and persistent depression in Pakistani women living in the UK. *Psychological Medicine,* 42 (06), 1217–1226.

Chew-Graham, C., Bashir, C., Chantler., Burman, E. & Batsleer, J. (2002) South Asian women, psychological distress and self-harm: lessons for primary care trusts. *Health and Social Care in the Community,* 10(5), 339-347.

Cochrane, R. (1977). Mental illness in immigrants in the U.K. and Wales: An analysis of mental hospital admissions. *Journal of Social Psychiatry, 12*(1), 25–31.

Cochrane, R. (1992). *The epidemiology of women and mental health in England.* Paper given at the International Conference of Women and Metal Health, London: UK

Commander, M., Sashidharan, S. P., Odell, S. M. & Surtees, P. G. (1997) Access to mental health care in an inner-city health district. II: Association with demographic factors. *British Journal of Psychiatry,* 70, 317-320.

Constantine, M.G. (2002) Predictors of satisfaction with counselling: racial and ethnic minority clients' attitudes toward counselling and ratings of their counsellors' general and multicultural competence. *Journal of Counselling Psychology* 49, 255–263.

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist, 59,* 614-625.

Cooper C., Spiers N., Livingston G. (2013) Ethnic inequalities in the use of health services for common mental disorders in England. *Social Psychiatry & Psychiatric Epidemiology,* 48 (5), 685–692.

Cooper, J. (2006) Self-harm in the UK: differences between South Asians and Whites in rates, characteristics, provision of service and repetition. *Social psychiatry and psychiatric epidemiology*, 44(12) 1024-1024

Cooper J., Murphy E., Webb R., Hawton, K., Bergen H., Waters K. & Kapur N. (2010) Ethnic differences in self harm rates, characteristics and service provision: three city cohort study. *The British Journal of Psychiatry,* 197 (3) 212–218.

Corrigan, P. & Penn, D. L. (1999**)** Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, 54, 765 -776.

Corrigan, P. W., Rowan, D., Green, A., Lundin, R., River, L., Uphoff Wasowski, K. (2002) Challenging two mental illness stigmas: Personal responsibility and dangerousness. *Schizophrenia Bulletin*, 28, 293–310.

Creed, F., Winterbottom, M., Tomenson, B., Britt, R., Anand, I.S., Wander,G.S. & Chandrashekhar, Y. (1999). Preliminary study of non-psychotic disorders in people from the Indian subcontinent living in the UK and India. *Acta Psychiatrica Scandinavica, 99,* 257–260.

Creswell, J. (2006). *Collecting Data in Mixed methods Research. Designing and Conducting Mixed Methods Research*. Sage Books: London.

Creswell, J.W., Klassen, A.C., Plano Clark, V.L. & Smith, K.C. (2011) Best practices for mixed methods research in the health sciences. Washington, DC: National Institutes of Health.

Cresswell, J.W. & Plano Clark, V. L. (2007). *Designing and conducting mixed methods research.* Thousand Oaks, CA: Sage.

Das, A.K. & Kemp, S.F. (1997). Between worlds: Counselling South Asian Americans. *Journal of Multicultural Counselling and Development*, 25, 23–33.

Deane, F. P. & Todd, D. M. (1996). Attitudes and intentions to seek professional psychological help for personal problems or suicidal thinking. *Journal of College Student Psychotherapy*, *10*(4), 45-59.

Department of Health, (2005). *Delivering Race and Equality An action plan for reform and the government's response to the independent inquiry into the death of David Bennett:* London: National Health Service.

Department of Health (2005) *Delivering Race Equality: A framework for Action.* London: Department of Health.

Department of Health (2009) *Improving Access to Psychological Therapies: Black and Minority (BME) Positive Practice Guide*. London: Department of Health.

Department of Health (2011) *No Health without Mental Health.* London: Department of Health.

Department of Health (1992) *The health of the nation: a strategy for health in England.* London: Department of Health.

Department of Health (2001) *The Journey to Recovery: the Government's Vision for Mental Health Care.* London: Department of Health.

Department of Health (2002) *Women's mental health: Into the mainstream.* London: Department of Health.

Donaghy, E. (1997) Understanding depression in young South Asian women in Scotland. In A. Bowes. & D. Sim. *Perspectives on welfare – the experience of minority ethnic groups in Scotland, 187-202*. Aldershot*:* Ashgate.

Duncan, L. E. (2003). Black male college students attitudes toward seeking psychological help. *Journal of Black Psychology, 29(1),* 68-86.

Fazil, Q. & Cochrane, R. (1998) *The cultural dimension in a causal model of depression.* Fourteen International Congress of Cross Cultural Psychology: Bellingham, WA.

Fazil, Q. & Cochrane, R. (2003). The prevalence of depression in Pakistani women living in the West Midlands. *Pakistani Journal of Women's Studies*, 10, 21–30.

Fenton, S. & Sadiq-Sangster, A. (1996) Culture, relativism and the expression of mental distress: South Asian women in Britain. *Sociology of Health and Illness*, 18, 66-85.

Fenton, S. & Sadiq-Sangster, A. (1993) *The sorrows of my heart-Sixteen Asian women speak about depression.* London: Commission for Racial Equality.

Fischer, E. H. & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form and considerations for research. *Journal of College Student Development, 36*(4), 368-373.

Fischer, E. H. & Turner, J. L. (1970). Orientations to seeking professional help: Development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology, 35*(1), 79-90.

Gable, S. L. & Haidt, J. (2005). What (and why) is positive psychology? *Review of general psychology, 9*(2), 103-110.

Gater, R., Tomenson, B., Percival, C., Chaudhry, N.,Waheed, W., Dunn, G., MacFarlane, G. & Creed, F. (2009). Persistent depressive disorders and social stress in people of Pakistani origin and white Europeans in UK. *Social Psychiatry and Psychiatric Epidemiology, 44*(3), 198–207.

Gaw, A. (1988) *Culture, Ethnicity and Mental Illness*. Washington DC: American Psychiatric Press.

Gibson M.A. (2001) Immigrant adaptation and patterns of acculturation. *Human Development*; 44 (19–23).

Gilbert, P., Gilbert, J. & Sanghera, J. (2004) A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby. *Mental Health, Religion and Culture*, 7(2), 109-130.

Gilroy, P. J., Carroll, L.,& Murra, J. (2002). A preliminary survey of counseling psychologists' personal experiences with depression and treatment. *Professional Psychology: Research and Practice, 33(4),* 402-407.

Glover, G. & Evison, F. (2009*) Use of new Mental Health Services by Ethnic Minorities in England.* Stockton on Tees: North East Public Health Observatory.

Gonzalez, J. M., Alegria, M. & Prihoda, T. J. (2005). How do attitudes toward mental health treatment vary by age, gender, and ethnicity/race in young adults? *Journal of Community Psychology, 33*(5), 611-629.

Gonzalez, J. M., Tinsley, H. E. A. & Kreuder, K. R. (2002). Effects of psychoeducational interventions on opinions of mental illness, attitudes toward help seeking, and expectations about psychotherapy in college students. *Journal of College Student Development*, *43*(1), 51-63.

Goodman, L. (1961) Snowball sampling. *Annals of Mathematical Statistics 32*(1), 148-170.

Guba, E. G., & Lincoln, Y. S. (1994) Competing paradigms in qualitative research. In Denzin, N. K., & Y. S. Lincoln, *Handbook of Qualitative Research.* Thousand Oaks, CA: Sage Publications.

Hall, R. (2012) Mixed methods: In search of a paradigm. In Thao, L. & Quynh, L, *Conducting research in a changing and challenging world.* Nova Science publishers.

Halgin, R. P., Weaver, D. D., Edell, W. S. & Spencer, P. G. (1987) Relation of depression and help-seeking history to attitudes toward seeking professional psychological help. *Journal of Counselling Psychology,* 34, 177-185.

Hayes, S.C. & Wilson, K.G. (2003). Mindfulness as a method and process. *Clinical Psychology: Science and Practice,* 10, 161–165.

Health and Social Care Information Centre (2013) *Mental Health Bulletin: Annual report.* London: HSCIC

Helman, C,G. (1990) *Culture, health and illness: an introduction for health professionals*. London: Wright.

Hussain, F. & Cochran, R. (2003) Living with depression: Coping strategies used by South Asian women suffering from depression. *Mental Health, Religion and culture,* 5(3), 21-44.

Hussain, M.I., Waheed, W. & Hussain, N. (2006) Self-harm in British South Asian women: psychosocial correlates and strategies for prevention. *Annals of General Psychiatry,* 1-7.

Husain, N., Cruickshank, J. K., Tomenson, B., Khan, S. & Rahman, A. (2012) Maternal depression and infant growth and development in British Pakistani women: a cohort study. *BMJ open*, *2*(2), e000523.

Jacob, K., Bhugra, D., Loyd, K. & Mann, A. (1998) Common mental disorders, explanatory models and consultation behaviour among Indian women living in the UK. *Journal of the Royal Society of Medicine*, 91, 66-71.

Jordan, R. (2009) Adapt, research and survive! Taking counselling psychology forward in to the next decade. *Counselling Psychology Review,* 24 (1), 11-14.

Joseph, S. & Murphy, D. (2013) Person-centred approach, positive psychology and relational building: Building bridges. *Journal of Humanistic Psychology, 53,* 26-51.

Kapadia, D., Louise Brooks, H., Nazroo, J. & Tranmer, M. (2015) Pakistani women's use of mental health services and the role of social networks: a systematic review of

quantitative and qualitative research. *Health and Social Care in the Community.*

doi:10.1111/hsc.12305

Kasket, E. & Gil-Rodriguez, E. (2011) The identity crisis in trainee counselling psychology research. *Counselling Psychology Review,* 26(4), 20-30.

Kasket, E. (2012) The counselling psychologist researcher. *Counselling Psychology Review,* 27(2), 64-73.

Keane, M. (1990) Contemporary beliefs about mental illness among medical students: Implications for education and practice. *Academic Psychiatry*, 14, 172–177.

Kelly, A. E., & Achter, J. A. (1995) Self-concealment and attitudes toward counselling in university students. *Journal of Counselling Psychology, 42, 4*0-46.

Kim, B., & Omizo, M. (2003) Asian cultural values, attitudes toward seeking professional psychological help, and willingness to see a counsellor. *The Counselling Psychologist*, 31, 343–361.

Kleinman, A. (1987) Anthropology and psychiatry: The role of culture in cross-cultural research on illness. *British Journal of Psychiatry, 151*, 447–454.

Komiya, N., Good, G. E. & Sherrod, N. B. (2000) Emotional openness as a predictor of college students' attitudes toward seeking psychological help. *Journal of Counselling Psychology, 47,*138-143.

Leong, F. T. L. & Zachar, P. (1999) Gender and opinions about mental illness as predictors of attitudes toward seeking professional psychological help. *British Journal of Guidance and Counselling, 27,* 123-132.

Littlewood, R. & Lipsedge, M. (1997) *Aliens and alienists*. London: Routledge.

Masood, Y., Lovell, K., Lunat, F., Atif, N., Waheed, W., Rahman, A.,Mossabi, R., Chaudhry, N. & Husain, N. (2015) Group psychological intervention for postnatal depression: a nested qualitative study with British South Asian women. *BMS Women's Health.* 15:109.

May, R. (2005) Some ways to holistic mental wellbeing. Paper given in Quebec. www.workingtogetherforrecovery.co.uk.

McCarthy, J., Pfohl, A. H. & Bruno, M. (2010) Help seeking among counselling trainees: An exploratory study. *Journal of Counselling Research and Practice,* 1(1), 53-63.

Meara, N.M. & Myers, R.A. (1999) A history of Division 17 (Counselling Psychology): Establishing stability amid change. In Dewsbury, D.A. *Unification through division: Histories of the divisions of the American Psychology Association*, 9-41. Washington, DC: American Psychological Association

Mental Health Foundation (2011) *Recovery and Resilience: Africa, Africa-Caribbean and South Asian women's narratives o recovering from mental distress*. London:

Mental Health Foundation. Retrieved 16th April 205, from https://www.mentalhealth.org.uk/publications/recovery-and-resilience/.

Mertens, D. M. (2003) Mixed methods and the politics of human research: the transformative emancipatory perspective. In Tashakkori, A. & C. Teddlie, *Handbook of Mixed Methods in Social and Behavioural Research.* Thousand Oaks, CA: Sage Publications.

Mind (2013) *Mental health crisis care: Commissioning excellence for Black and Minority ethnic groups*. London: Mind. Retrieved 23rd January 2017, from https://www.mind.org.uk/media/494422/bme-commissioning-excellence-briefing.pdf

Mind (2011) *The first step: An exploration of how Croydon's Black and Minority Ethnic communities access counselling services*. Surrey: Mind. Retrived 23rd January 2017, from http://www.mindincroydon.org.uk/DocumentLibrary/CounsellingBMEReportThFirstStep.pdf

Moller, N. (2011) The identity of counselling psychology in Britain is parochial, rigid and irrelevant but diversity offers a solution. *Counselling Psychology Review, 26*(2), 8-16.

Morgan, D.L. (2007) Paradigms lost and pragmatism regained: Methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods Research, 1*, 48-76.

Murray, M. (2003) Narrative psychology and narrative analysis. In Camic, P.M., Rhodes, J.E. & Yardley, L. *Qualitative research in psychology,* 95-112. Washington, DC, American Psychological Association.

Nazroo, J.Y. (1997). *Ethnicity and mental health: Findings from a national community survey*. London: Policy Studies Institute.

Nazroo, J. (1997) *Ethnicity and Mental Health*. Grantham Books, London.

Neeleman, J., Mak, V. & Wessely. (1997) Suicide by age, ethnic group, coroner's verdicts, and country of Birth: a three-year survey in inner London. *British Journal of Psychiatry,* 171:463-467.

Netto, G., Gaag, S., Thanki, M., Bondi, L, & Munro, M. (2001) *A suitable space; Improving counselling services for Asian people.* The Joseph Rowntree Foundation: Bristol. Retrieved 13th June 2015, from http://www.better-health.org.uk/resources/research/suitable-space-improving-counselling-services-asian-people

Nunnally J. C. (1961) *Popular conceptions of mental health*. New York: Holt, Rinehart & Winston.

Patel, S. P. & Gaw, A. C. (1996) Suicide amongst immigrants from the Indian subcontinent: a review. *Psychiatric Services,* 47 (5), 517-521.

Patton, M. Q. (1990) *Qualitative evaluation and research methods* (2nd ed). Thousand Oaks: Sage.

Pilkington, A., Msetfi, M.R. & Watson, R (2012) Factors affecting intention to access psychological services amongst British Muslims of South Asian origin. *Mental Health, Religion & Culture* 15 (1), 1-22.

Repper, J. & Perkins, R. (2003) *Social Inclusion and Recovery.* London: Bailliere Tindall.

Riessman, C.K. (1993) Narrative Analysis. *Qualitative Research Methods Series No. 30.* Newbury Park, CA: Sage.

Robitschek, C. & Woodson, S.J. (2006) Vocational psychology: Using one of counselling psychology's strengths to foster human strength. *The Counselling Psychologist, 34, 260-275.*

Rout, J. & Rout, U. (2010) Psychological stress and mental health among South Asian women brought up in the UK. *European Psychiatry*, 25, 1410.

Rugkåsa, J. & Canvin, K. (2011) Researching Mental Health in Minority Ethnic Communities: Reflections on Recruitment. *Qualitative Health Research* 21(1): 132-43. DOI: 10.1177/1049732310379115

Ryan, G. W. & Bernard, H. R. (2000). Data management and analysis methods. In Denzin, N.K. & Lincoln, Y.S. *Handbook of Qualitative Research*, 769-802. Thousand Oaks, CA: Sage.

Said, E. (1978) *Orientalism.* London: Penguin.

Sainsbury Centre for Mental Health (2002) *Breaking the Circles I Fear: A review of the relationships Between Mental Health Service and African Caribbean communities.* London: SCMH.

Segal, Z., Williams, J. & Teasdale, J. (2002) Review of mindfulness-based cognitive therapy for depression. *Journal of Psychiatry & Law*, 30, 271–274.

Seligman, M.E.P. & Csikszentmihalyi, M. (2000) Positive psychology: An introduction. *American Psychologist*, 55(1), 5-14

Sewell, H. (2009) *Working with Ethnicity, Race and Culture in Mental Health*. London: Jessica Kingsley.

Sheikh, S. & Furnham, A. (200) A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. *Social Psychiatry and Psychiatric epidemiology*, 35, 326-334.

Shin, S. K. & Lukens, E. P. (2002) Effects of Psychoeducation for Korean Americans with chronic mental illness. *Psychiatric Services,* 53(9), 1125–1131. doi:10.1176/appi.ps.53.9.1125

Silveira, E. & Shah, E. (1998) Social determinants of psychiatric morbidity and well-being in immigrant elders and whites in East London. *International Journal of Geriatric Psychiatry*, 801-12.

Smith, L.D., Peck, P.L. & McGovern, R.J. (2004) Factors contributing to the utilization of mental health services in a rural setting. *Psychological Reports*, 95, 435–442.

Sonuga-Barkes, E.J.S. & Mistry (2000) The effect of extended family living on the mental health of three generations within two Asian communities. *British Journal of Clinical Psychology, 39*, 129–141.

Speer, P. W., Jackson, C. B. & Peterson, N. A. (2001) The relationship between social cohesion and empowerment: Support and new implications for theory. *Health Education & Behavior, 28*(6), 716–732.

Sproston, K. & Nazroo, J. (2002) *Ethnic minority psychiatric illness rates in the community (EMPIRIC) – Quantitative report*. London: The Stationery Office.

Steffen, E., Vossler, A. & Joseph, S. (2015) From shared roots to fruitful collaboration: How counselling phsychology can benefit from (re) connecting with positive psychology. *Counselling Psychology Review, 30 (3),* 1-11.

Strawbridge, S. & Woolfe, R. (2003) Counselling psychology in context. In Woolfe, R., Dryden, W. & Strawbridge, S. *Handbook of counselling psychology* (2nd ed.) 3-22. London: Sage.

Strawbridge, S. & Woolfe, R. (2010) Counselling psychology: Origins, developments and challenges. In Woolfe, R., Strawbridge, S., Douglas, B. & Dryden, W. *Handbook of counselling psychology* (3rd ed.) 3-22. London: Sage.

Sue, W.S. & Sue, D. (2003) *Counselling the culturally diverse: Theory and practice (4th ed.).*New York: Wiley.

Tabassum, R., Macaskill, A. & Ahmad, I. (2000) Attitudes Towards Mental Health in an Urban Pakistani Community in the United Kingdom. *International Journal of Social Psychiatry,* 46(3),170-181.

Tariq, S. & Woodman, J. (2013) Using Mixed Methods in Health Research. *Journal of the Royal Society of Medicine Short Reports*, 4, 2042533313479197. http://dx.doi.org/10.1177/2042533313479197.

Tashakkori, A. & Teddlie, C. (2003) The past and future of mixed methods research: From data triangulation to mixed model designs. In Tashakkori, A. & Teddlie, C. *Handbook of Mixed Methods in Social and Behavioral Research.* Thousand Oaks, CA: Sage Publications.

Tata, S.P. & Leong, F.T.L. (1994) Individualism-collectivism, social-network orientation, and acculturation as predictors of attitudes toward seeking professional psychological help among Chinese Americans. *Journal of Counselling Psychology*, 41, 280–287.

Teddlie, C. & A. Tashakkori (2009) *Foundations of Mixed Methods Research.* Thousand Oaks, CA: Sage Publications.

Terrell, F. & Terrell, S. L. (1984) Race of counsellor, client sex, cultural mistrust level, and premature termination from counselling among black clients. *Journal of Counselling Psychology, 31,* 371-375.

Tinsley, H. E. A., Workman, K. R. & Kass, R. A. (1980) Factor analysis of the domain of client expectancies about counselling. *Journal of Counselling Psychology*, *27*, 561–570.

Vogel, D.L., Wester, S.R., Wei, M. & Boysen, G.A. (2005) The role of outcome expectations and attitudes on decisions to seek professional help. *Journal of Counselling Psychology,* 52, 459–470.

Vossler, A., Steffen, A. & Joseph, S. (2015) The relationship between counselling psychology and positive psychology. In Joseph, S. *Positive Psychology in practice: Promoting human flourishing in work, health, education and everyday life* (2nd ed), 429-442. Hoboken, NJ: John Wiley & Sons.

Wallcraft, J. (2002) Turning towards Recovery? A study of Personal Narratives of Mental Health Crisis and Breakdown. Unpublished Phd thesis: South Bank University.

Wang, S.-C. & Guo, Y.J. (2011) Counselling students attitudes towards research methods class. Retrieved from http://counsellingoutftters.com/vistas/vistas11/Article_30.pdf

Webb-Johnson, A. (1995) *A cry for change.* London: Confederation of Indian Organisations.

Weich, S., Naroo, J., Sproston, K., McManus, S. & Blanchard, M. (2004). Common mental disorders and ethnicity in England: the EMPIRIC Study. *Psychological Medicine*, 34(08), 1543-1551.

Weiss, M., Raguram, R. & Channabasavanna, S. (1995) Cultural dimensions of psychiatric diagnosis: a comparison of DSM-111-R and illness explanatory models in South India. *British Journal of Psychiatry*, 166, 353-59.

Wilson, M. & MacCarthy, B. (1994) GP consultation as a factor in the low rate of mental health service use by Asian. *Psychological Medicine*, 24, 113-119.

Wittchen, HU. (2000) Epidemiological research in mental disorders: lessons for the next decade of research. *Acta Psychitrica Scandinavica*, 101, 2-10.

Wright, S. & Hutnik, N. (2003) *Strategies for living, South Asian Women Study*. Mental Health Foundation, London.

Wynaden, D, Chapman, R. & Orb, A. (2005) Factors that influence Asian communities' access to mental health care. *International Journal of mental health Nursing, 14(2*), 88-95.

Zhang, N., & Dixon, D. (2003) Acculturation and attitudes of Asian international students toward seeking psychological help. *Journal of Multicultural Counselling and Development*, 31, 205–222.

Appendix A – Research proposal

UNIVERSITY OF WOLVERHAMPTON

RES 20A

(October 2003)

Behavioural Sciences Ethics Committee:

submission of project for approval

To be completed by SEC:
Date Received:
Project No:

- **This form must be word processed – no handwritten forms can be considered**
- **ALL sections of this form must be completed**
- **No project may commence without authorisation from the Divisional and School Ethics Committees**

CATEGORY A PROJECTS:

There is no significant interference with participants' physical or psychological wellbeing. In detail:

• The research procedure is not likely to be stressful or distressing.

• The research materials are not of a sensitive, discriminatory or otherwise inappropriate nature.

• The participants are not members of a vulnerable group, such as those with a recognised clinical or psychological or similar condition.

• The research design is sufficiently well-grounded so that the participant's time is not wasted.

Projects involving access to confidential records may be considered Category A provided that the investigator's access to these is part of his/her normal professional duties.

Category A projects will be approved by the Behavioural Sciences Ethics Committee and monitored by the School Ethics Committee. The School Ethics Committee will not normally examine individual Category A projects but receives a record of projects that have been approved by BSEC.

Title of Project:	Mental Health help seeking experiences of British South Asian Women: Overcoming the barriers
Name of Supervisor: (for all student projects)	Dr Richard Darby, Dr Victoria Galbraith
Name of Investigator(s):	Mehmoona Ashiq
Level of Research: (Module code, MPhil/PhD, Staff)	PhD
Qualifications/Expertise of the investigator relevant to the submission:	Trainee Counselling Psychologist

Participants: Please indicate the population and number of participants, the nature of the participant group and how they will be recruited.	For Part A of the study (Interviews) 5-8 participants will be recruited. These participants will be British Born South Asian Women, aged between 18-45 who have had experience of overcoming barriers in order to access therapeutic help. These participants will be recruited in two ways: 1.Posters will be placed in local community settings such as local

	women's centres asking participants to get in touch if they are interested in taking part. 2. Letters will be sent out to private counselling services/psychologists, relevant departments in Birmingham and Solihull Mental Health NHS trust and local G.P surgeries asking for the investigators details to be passed on to any potential participants who may fit the criteria.
	• **Please note, there are two parts to this research however at this stage, ethical approval is only being sought for Part A. Materials and tools for Part B will be finalised and submitted once Part A is complete.**

Continued overleaf

Mehmoona Ashiq
Doctoral Portfolio in Counselling Psychology

Please attach the following and tick the box* provided to confirm that each has been included:

**in the case of undergraduate projects, this should be done by supervisors to confirm that each part is properly constituted*

Rationale for and expected outcomes of the study	✓
Details of method: materials, design and procedure	✓
Information sheet* and informed consent form for participants **to include appropriate safeguards for confidentiality and anonymity*	✓
Details of how information will be held and disposed of	✓
Details of if/how results will be fed back to participants	✓
Letters requesting, or granting, consent from any collaborating institutions	✓
Letters requesting, or granting, consent from head teacher or parents or equivalent, if participants are under the age of 16	**n/a**
Is ethical approval required from any external body? YES (delete as appropriate) **If yes, which committee?** Local NHS ethics committee (Birmingham) *NB. Where another ethics committee is involved, the research cannot be carried out until approval has been granted by both the School committee and the external committee.*	

Signed: Date: 9/4/13

Mehmoona Ashiq

(Investigator)

Signed: Date:

(Supervisor)

Mehmoona Ashiq
Doctoral Portfolio in Counselling Psychology
Except in the case of staff research, all correspondence will be conducted through the supervisor.

FOR USE BY THE SCHOOL ETHICS COMMITTEE

Divisional Approval Date:

Granted:

(Chair of BSEC)

School Approval

Granted: Date

(Chair of School Ethics

Committee)

Appendix B – Ethics approval letter

Date: 16th September 2013

Mehmoona Ashiq

Psychology student

Dear Mehmoona,

Re: Mental Health help seeking experiences of British south Asian women: overcoming the barriers

Submitted to the Faculty of Education, Health and Wellbeing Ethics Sub-Committee Board (Health Professions, Psychology & Social Care)

The Faculty Ethics Sub-Committee (Health Professions, Psychology & Social Care) met on **16th September 2013.** Your project was considered and reviewed at this meeting. On review your research proposal was passed and given approval **(Code 2 – Pass (Researcher/Supervisor to Monitor).** You are free to begin your study contingent on addressing any minor amendments detailed below.

(Paragraph for students with supervisors only)

Supervisors must ensure the minor amendments have been completed prior to commencement of data collection.

We would like to wish you every success with the project.

Yours sincerely

H Paniagua

Dr. H. Paniagua PhD, MSc, BSc (Hons) Cert. Ed. RN RM

Chair – School Ethics Committee

D Chadwick

Dr. D. Chadwick PhD, MSc, BA (Hons). PGCE

Chair – School Ethics Committee

Appendix C – Interview schedule

Interview schedule for Qualitative interviews for exploring the Mental Health help seeking experiences of British South Asian Women: Overcoming the barriers

1. Could you begin by telling me a bit about yourself and your life at present?

   (Work, family etc)

2. Can you tell me about the circumstances that lead you to access therapeutic help?

   (Specific mental health issues, self - referral or professional referral, what kind of therapeutic help was considered and then eventually accessed)

3. What specific barriers did you have to face in accessing the help?

   (Personal, contextual, environmental, cultural, barriers specific to service)

4. What difficulties did you face in overcoming these barriers?

5. What eventually helped you to overcome these barriers?

   (Specific details)

6. Tell me a bit about your experience of therapy?

   (What was helpful, what wasn't helpful).

7. How has your life changed since you have accessed therapeutic help?

8. What would you say to the therapeutic services out there that are available to South Asian women?

   (What can they do to encourage SAW to access help, what can they do to cater the services to address the concerns of SAW)

9. What would you say to SAW who may be experiencing similar problems to the ones that you experienced, but may be reluctant, or hesitant to access help?

(What would you say to help them overcome any barriers they may be facing).

Appendix D – Letter sent out to relevant organisations

Dear Sir/Madam

My name is Mehmoona Ashiq and I am a trainee Counselling Psychologist at the University of Wolverhampton. I am conducting some research into the mental health help seeking experiences of British Born, South Asian women. I am therefore writing to ask if you have worked with any women that fit the criteria of this research, who you believe may be willing to take part in it.

The research will involve carrying out qualitative interviews with women aged between 18-45. The main aim will be to explore the types of mental health problems they experienced, the kind of help they sought, the barriers they faced and more importantly, how they overcame these barriers and successfully accessed therapeutic help. The themes generated from these initial interviews will then be fed into a psycho-educational group which will be used to encourage other women who may be in similar positions, to access help. Potential participants will have completed their therapy and would have reported it as having been beneficial. Thus this project is focusing on the positive outcomes of therapy and aims to help shape and influence future service provision and tackle the issue of low service uptake by South Asian Women.

If you know of any women who may be appropriate for this study, it would be greatly appreciated if you could contact these women and speak to them about the research, and pass on my contact details should they express an interest in taking part.

This research project has been approved by the University's Behavioural Sciences Ethics Committee. The research will be carried out under the supervision of Dr Richard Darby and Dr Victoria Galbraith.

Please do not hesitate to contact me if you require any further information and I look forward to hearing from you in the future.

Yours sincerely,

Mehmoona Ashiq

Trainee Counselling Psychologist

Mehmoona.Ashiq@wlv.ac.uk

07722061708

Appendix E – poster used to recruit participants

UNIVERSITY OF WOLVERHAMPTON

Poster Part A

Help seeking experiences of British born South Asian Women: Overcoming the barriers

- Are you a British Born South Asian woman, aged between 18-45?

- Have you successfully accessed any kind of therapeutic help (E.g. seen a Psychologist or a counsellor)

- Can you identify any barriers that you faced in accessing this help?

- Would you like an opportunity to explore how you overcame these barriers, to encourage other women who may be reluctant to access help?

- If the answer is yes to the above questions, then I would like to hear from you!

My name is Mehmoona Ashiq and I am a trainee Counselling Psychologist at the University of Wolverhampton. I am doing some research into how South Asian Women successfully overcome barriers to access therapeutic help.

The aim of this research is to speak to women who fit the above criteria in order to hear their experiences and generate ideas that can be used to encourage other women to access help.

The research will involve talking me through your process of accessing therapeutic help. If you feel that you would like to take part in this research then please contact the centre and leave your contact details. I will then arrange to meet with you and explain the research and your possible participation in more detail.

Mehmoona Ashiq

Trainee Counselling Psychologist

Appendix F – Participant information sheet

- This sheet will be given to participants to read, if they cannot read, then the researcher will read this out to the participant and ensure they have understood everything on it.

Participant Information Sheet Part A

This information sheet will provide you with information on the research project to help you decide whether or not you wish to take part. This project is being carried out by Mehmoona Ashiq, a trainee Counselling Psychologist at the University of Wolverhampton and is being supervised by Dr Richard Darby and Dr Victoria Galbraith. The research has received ethical clearance from the University of Wolverhampton's Behavioural Sciences Ethics Committee as well as the *local NHS research committee.

The aim of this research is to get a better understanding of the help seeking experiences of British Born South Asian women. Your participation in this research will involve taking part in an interview with the researcher lasting approximately an hour and a half,

to talk about what helped you in accessing help, what barriers you faced and how you overcame these barriers.

The interview will be arranged at a mutually convenient time and place. The interview will be transcribed and qualitatively analysed by the researcher. The ideas generated from the interview will then be fed into a psycho-educational group which will be used to encourage other women, who may be in similar positions, to access help.

Thus this project is focusing on the positive outcomes of therapy and aims to help shape and influence future service provision and tackle the issue of low service uptake by South Asian Women.

If you agree to take part, you will have an opportunity to speak to the researcher to clarify any queries before signing a consent from. However, your participation is entirely voluntary, and even after you have signed the consent form, you are free to withdraw from the research up until the interviews are analysed, without having to give a reason. It will not be possible to withdraw your data from the research once analysis has begun, as the researcher will be working towards a deadline for completion of the research in order to pass the course.

You will be given a full debrief once the interview has been carried out that will address any concerns/queries you may have.

All the data will be collected and held confidentially. The data will be anonymised prior to reporting and this may include deleting your name, or names of other people you

speak about in the interview, from the transcript or a number or code name being used to report the data. The transcript will be viewed by the researcher (Mehmoona Ashiq), the supervisors (Dr Richard Darby and Dr Victoria Galbraith) and external examiners.

Once the research project has been completed, the researcher aims to submit it for publication in relevant academic journals. The tape recording and transcript will be kept in a secure place by the researcher and will be destroyed within three years of the research completion.

If at any point during the interview you find it distressing to talk about your experiences, we can stop the interview. If you continue to feel distressed you should contact your G.P in the first instance or you can contact the Samaritans, who provide 24 hour telephone support for people experiencing emotional distress, on 08457 90 90 90 .

Please do not hesitate to ask the researcher (Mehmoona.Ashiq@wlv.ac.uk) or her supervisor (R.Darby@wlv.ac.uk) if you require any further information about this project.

Thank you for taking the time to read this sheet and for expressing an interest in taking part.

Appendix G – Participant consent form

- This sheet will be given to participants to read and complete. If they cannot read, the researcher will read this out to the participant, ensure they have understood everything on it and help them to complete it.

Participant Consent Form Part A

Research project title: **Mental Health help seeking experiences of British South Asian Women: Overcoming the barriers**

Researcher name: **Mehmoona Ashiq**

***Please initial each box**

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask any questions

☐

2. I understand that my participation in the research is completely voluntary and that I am free to withdraw from the research up until the interview is analysed, without having to give a reason.

☐

3. I agree to the interview being tape recorded.

☐

4. I agree to the ideas discussed in the interview being presented in a psycho-educational group.

☐

5. I understand that any identifiable information will be anonymised.

☐

6. I understand that once this research is complete, it will be submitted for publication in various academic journals.

☐

7. I agree to take part in the above research.

☐

Name or initials of Participant ……

Signature or initials of Participant …….....

Date …….

Researcher signature ……

Appendix H – Participant demographic questionnaire

- This sheet will be given to participants to read and complete. If they cannot read, the researcher will read this out to the participant, ensure they have understood everything on it and help them to complete it.

Demographic Questionnaire Part A

Please fill out the following information

Age……

What South Asian subgroup do you belong to? (please circle)

Indian Pakistani Bangladeshi Sri Lankan

Other…….

Marital Status (please circle)

Married Single Divorced Widowed Separated Co-habiting

What is your education level?

……

How long ago did you access therapeutic help? (please circle)

6-12 months 1-2 years 2 years+

Appendix I – Participant debrief sheet

- This sheet will be given to participants to read, if they cannot read, then the researcher will read this out to the participant and ensure they have understood everything on it.

Debrief sheet Part A

Research project title: **Mental Health help seeking experiences of British South Asian Women: Overcoming the barriers**

Thank you for taking part in the above research project.

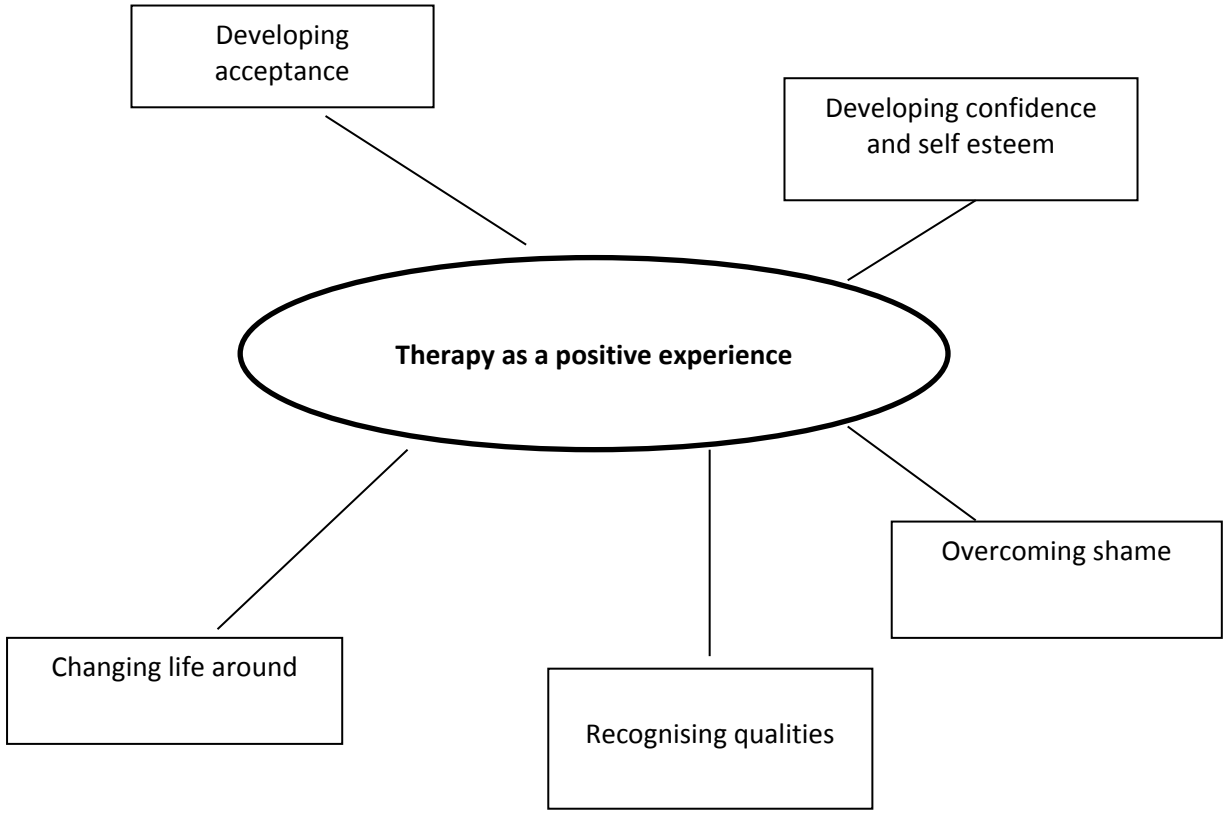
The aim of this research is to get an understanding of how British born South Asian Women are able to overcome any barriers they may face, and go onto successfully access therapeutic help. It is hoped that the ideas generated in the initial interview stage of this research can be used to encourage other women in similar positions to access help.

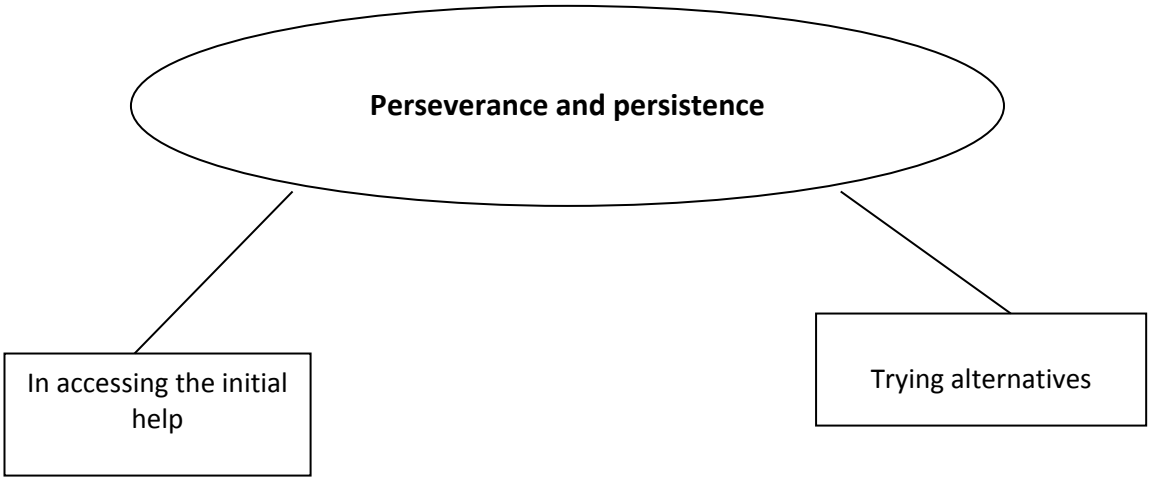
If your participation in this research has generated any feelings of distress then please contact your G.P or the Samaritans on 08457 90 90 90.

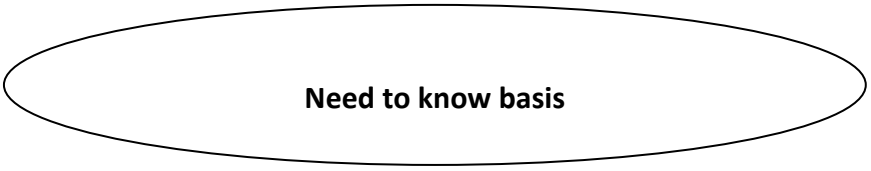
If you would like any further information, express any concerns or like to see this research project once it has been completed, then please do not hesitate to contact the researcher (Mehmoona.Ashiq@wlv.ac.uk) or her supervisor (R.Darby@wlv.ac.uk).

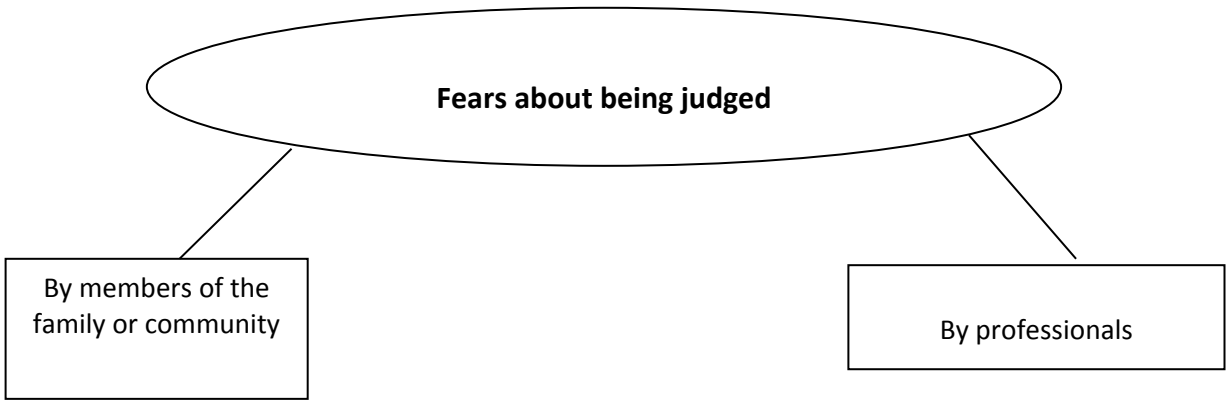
Thank you once again for your valuable contribution to this research project.

Appendix J – thematic map of themes

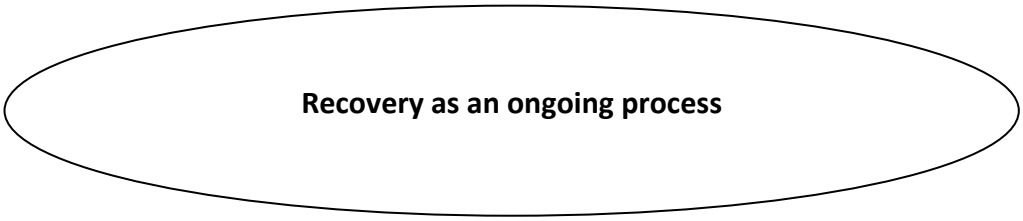


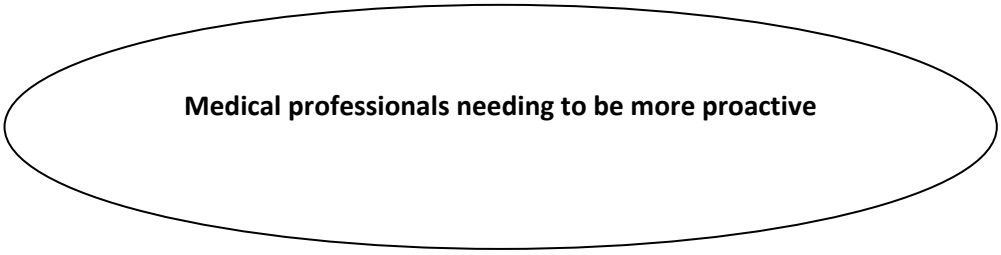

Perseverance and persistence
In accessing the initial help
Trying alternatives

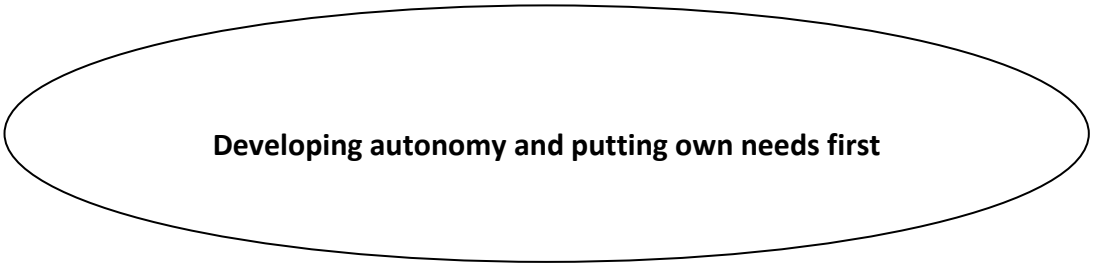

Need to know basis

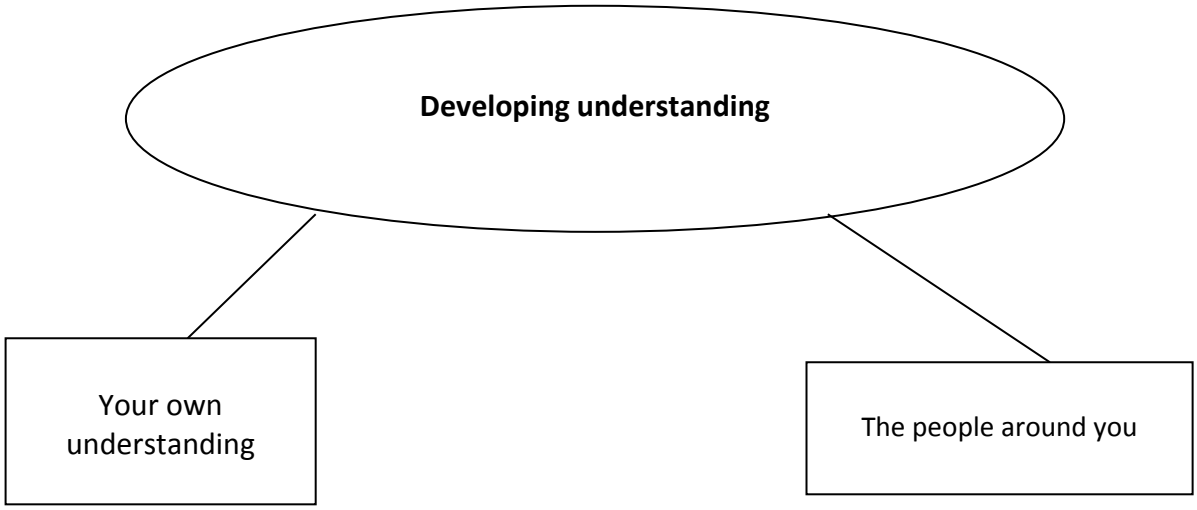

Fears about being judged
By members of the family or community
By professionals

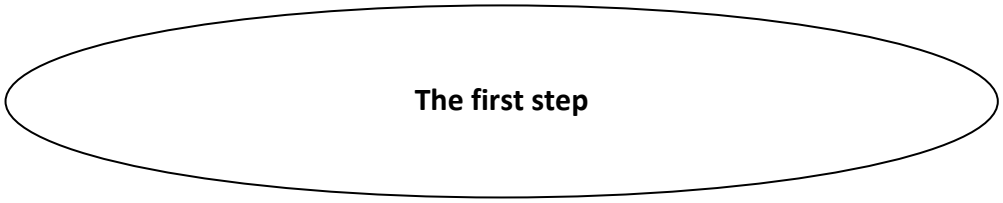

The need for publicising and awareness


Recovery as an ongoing process


Medical professionals needing to be more proactive


Developing autonomy and putting own needs first


Developing understanding
Your own understanding
The people around you


The first step

Appendix K – Questionnaire used to measure attitudes

Please complete all questions

Attitudes towards Seeking Professional Psychological Help Scale (ATSPPH)- Fischer and Farina 1995

To what extent do you agree or disagree with the statements below, please circle:

	Disagree	Partly Disagree	Partly Agree	Agree
1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	1	2	3	4
2. The idea of talking about problems with a psychologist strikes me as a	1	2	3	4

	poor way to get rid of emotional conflicts.				
3.	**If I were experiencing a serious emotional crisis at this point in my life. I would be confident that I could find relief in psychotherapy.**	1	2	3	4
4.	**There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears *without* resorting to professional help.**	1	2	3	4
5.	**I would want to get psychological help if I were worried or upset for a long period of time.**	1	2	3	4
6.	**I might want to have psychological counselling in the future.**	1	2	3	4
7.	**A person with an emotional**	1	2	3	4

	problem is not likely to solve it alone; he or she *is* likely to solve it with professional help.			
8.	**Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.**	1	2	3	4
9.	**A person should work out his or her own problems; getting psychological counselling would be a last resort.**	1	2	3	4
10.	**Personal and emotional troubles, like many things, tend to work out by themselves.**	1	2	3	4

Appendix L – Research proposal

1. ETHICS APPLICATION FORM:

PSYCHOLOGY, HEALTH, SOCIAL WORK & SOCIAL CARE

1. Please enter your surname and first name below. (SURNAME, FIRST NAME)
Ashiq, Mehmoona

2. Please enter your University e mail address (e.g. M.Name@wlv.ac.uk)
Mehmoona.Ashiq@wlv.ac.uk

3. Please enter the name of your Project Supervisor, Director of Studies, or Principal Investigator.
Dr Richard Darby

4. Please enter date by which a decision is required below. (Note that decisions can take up to 4 working weeks from date of submission)
20th Feb 2015

5. Which subject area is your research / project located?
1. Science (including Pharmacy) 2. Engineering & the Built Environment 3. Computing 4. **Health and Wellbeing (including Psychology)** 5. Education 6. Business 7. Social Sciences & Humanities 8. Art 9. Sport

6. Please select your Faculty, Department or Research Centre
1. Faculty of Social Science
2. Faculty of the Arts
3. Faculty of Science and Engineering
4. **Faculty of Education Health and Wellbeing**
5. CADRE
6. CEDARE
7. Centre for Discourse and Cultural Studies
8. Engineering and Computer Science Research Centre
9. CHSCI
10. RIHS
11. Centre for Historical Research
12. RILLP
13. Centre for Research in Law
14. Centre for Transnational and Transcultural Research
15. Management Research Centre
16. RCSEP
17. Centre for Academic Practice
18. IT Services
19. Human Resources
20. Learning Information Services
21. Registry
22. Don't know
23. Other (please specify below)

7. Does your research fit into any of the following security-sensitive categories? (For definition of security sensitive categories see RPU webpages (www.wlv.ac.uk/rpu) follow links to Ethical Guidance).
1. commissioned by the military
2. commissioned under an EU security call
3. involve the acquisition of security clearances
4. concerns terrorist or extreme groups
5. not applicable

8. Does your research involve the storage on a computer of any records, statements or other documents that can be interpreted as promoting or endorsing terrorist acts?
1. YES **2. NO**

9. Might your research involve the electronic transmission (eg as an email attachment) of any records or statements that can be interpreted as promoting or endorsing terrorist acts?
1. YES **2. NO**

10. Do you agree to store electronically on a secure University file store any records or statements that can be interpreted as promoting or endorsing terrorist acts. Do you also agree to scan and upload any paper documents with the same sort of content. Access to this file store will be protected by a password unique to you. Please confirm you understand and agree to these conditions?
1. YES I understand and agree to the conditions 2. NO (please explain below) 3. I do not understand the conditions

11. You agree NOT to transmit electronically to any third party documents in the University secure document store?
1. YES I agree 2. NO I don't agree

12. Will your research involve visits to websites that might be associated with extreme, or terrorist, organisations? (for definition of extreme or terrorist organisations see RPU webpages (www.wlv.ac.uk/rpu) and follow links to Ethical Guidance.
1. YES (Please outline which websites and why you consider this necessary) **2. NO**

13. You are advised that visits to websites that might be associated with extreme or terrorist organisations may be subject to surveillance by the police. Accessing those sites from university IP addresses might lead to police

enquiries. Do you understand this risk?

1. YES I understand

2. NO I don't understand

14. What is the title of your project?

Mental Health help seeking experiences of British South Asian Women: Overcoming the barriers

15. Briefly outline your project, stating the rationale, aims, research question / hypothesis, and expected outcomes.

This research project will focus on the help seeking experiences of British born South Asian women. According to the 2001 Census, South Asians are the largest minority group in the United Kingdom. Research suggests that there is a huge number of South Asian women (SAW) suffering with mental health problems such as depression and eating disorders (Bhugra & Bhui, 2003, Fazil & Cochrane, 2003). Furthermore, research carried out by Neeleman, Mak and Wessley (1997) highlighted that SAW are twice as likely to commit suicide compared to their White counterparts. However, the high numbers of SAW suffering with mental health is disproportionate to the limited research that has been carried out in this area, especially with regards to interventions and help seeking (Wittchen, 2000).

Much of the research in this area has focused on identifying the various barriers that SAW face in accessing help. These barriers include language, cultural differences and fear of stigma (Hussain and Cochrane 2004). Further research has shown that the help-seeking journey and chosen forms of treatment is often influenced by a variety of factors. For e.g. research by Hussain and Cochrane (2003) seems to suggest that SAW women tend to limit their help seeking to avenues which fitted in with their cultural and religious beliefs.

With regards to trends in research in this area, it seems that identifying the various barriers SAW face is where the story seems to end. There is very scarce research, if any, on SAW who have experienced mental ill health and successfully sought help; there is little focus on carrying out research to get an in-depth understanding of *their* experiences.

This project will aim to fill this gap in the research and focus on the types of mental health problems SAW have experienced, the kind of help they sought, the barriers they faced and more importantly, how they overcame these barriers and successfully accessed therapeutic help.

The project will be split into two parts**.*Please note ethical clearance was granted for part A of the study and this has now been completed*** The first part involved carrying out semi-structured qualitative interviews with 6 women who had successfully accessed help. ***Themes generated from these interviews will be fed into part B of the study which this ethics application is referring to***

Therefore, not only will this project focus on generating ideas of how to overcome the barriers, it will go a step further and implement an intervention technique based on these ideas.

This research idea is linked to Counselling Psychology as it focus on the positives outcomes of therapy and will thus aims to help shape and influence future service provision and tackle the issue of low service uptake by South Asian Women.

16. How will your research be conducted?

Describe the methods so that it can be easily understood by the ethics committee. Please ensure you clearly explain any acronyms and subject specific terminology. Max 300 words

Part B will involve carrying out a psycho-educational group with 20-25 SAW, who

have ideally not accessed therapeutic help and may be reluctant/ hesitant to do so. Recruitment will take place in the following ways:

1. Posters will be placed in local community settings such as local women's centers/sure start centers asking participants to get in touch if they are interested in taking part.

2. Letters will be sent out to local women's center's/organisations asking for the investigators details to be passed on to any potential participants who may fit the criteria.

Once enough participants have been identified, the researcher will arrange a time/place for the group to run and participants will be informed of this. The venue will most likely be in a local community centre.

The group will be in a power point format (see appendix for presentation). The researcher will deliver an awareness building, workshop style presentation using the Power point. There will be opportunities during the presentation for the participants to ask questions as well as taking part in group discussions. Participants' attitudes to help seeking will be measured at three points; before the group, immediately after and two or four weeks later. The data will be quantitatively analysed to see whether there was a significant difference in attitudes towards help seeking after the psych-educational group.

17. Is ethical approval required by an external agency? (e.g. NHS, company, other university, etc.)

1. NO

2. YES - but ethical approval has not yet been obtained

3. YES - see contact details below of person who can verify that ethical approval has been obtained)

18. What in your view are the ethical considerations involved in this project? (e.g. confidentiality, consent, risk,

physical or psychological harm, etc.) Please explain in full sentences. Do not simply list the issues. (Maximum 100) words)

- Confidentiality has been explained to participants on the information sheet and consent form (see appendix)
- Participant's informed consent will be obtained. (See consent form/information sheet in appendix)
- It is not anticipated that participants will be at any physical risk. There is a small chance that participants may become slightly distressed due to the content of the group but they will be given information on this and will be told they can withdraw at any time should they feel the need to do so. Relevant contact numbers will also be provided for further help (See information sheet)

19. Have participants been/will participants be, fully informed of the risks and benefits of participating and of their right to refuse participation or withdraw from the research at any time?

1. **YES (Outline your procedures for informing participants in the space below**).

   This process has been explained to participants in the information sheet they will be given before they take part in the study (see appendix)

2. NO (Use the space below to explain why)
3. Not applicable - There are no participants in this study

20. Are participants in your study going to be recruited from a potentially vulnerable group? (See RPU website (www.wlv.ac.uk/rpu) and follow link to Ethical Guidance pages for definition of vulnerable groups)

1. YES (Describe below which groups and what measures you will take to respect their rights and safeguard them)
2. **NO**

21. How will you ensure that the identity of your participants is protected (See RPU website (www.wlv.ac.uk/rpu) and follow link to Ethical Guidance pages for guidance on anonymity)

Participation in this research will remain entirely anonymous. Actual names or any identifying information about participants will not be collected. It will not be possible to link participants to responses on the questionnaire. Participants will be given a number each. The three questionnaires to be used throughout the study will be stapled together with the participant's number on the front. This will help keep each participant's responses together.

22. How will you ensure that data remains confidential ((See RPU website (www.wlv.ac.uk/rpu) and follow link to Ethical Guidance pages for definition of confidentiality)

The data will be kept strictly confidential and where necessary, a number or code name will be used to report the data. Responses to the questionnaire will be viewed by the researcher (Mehmoona Ashiq), the supervisors (Dr Richard Darby and Dr Victoria Galbraith) and external examiners.

23. How will you store your data during and after the project? (See RPU website (www.wlv.ac.uk/rpu) and follow link to Ethical Guidance pages for definition of and guidance on data protection and storage).

During the process of the research, data will be stored on a password protected laptop which can only be accessed by the researcher. This will be stored in a locked cabinet when not in use.

Once the research project has been completed, the researcher aims to submit it for publication in relevant academic journals. The responses will be kept in a secure place by the researcher and will be destroyed within three years of the research completion.

24. Append study documentation to this form (Please append below the materials you will use to carry out your study. These should typically include letters of contact, consent forms, information sheets, data collection materials (e.g. interview schedules, surveys, experimental materials, training and intervention materials etc.), debrief and, if appropriate, a risk assessment document/lone worker policy.)

Appendix M – Ethics approval

Name: _____Mehmoona Ashiq

Date: -------16th September 2013----------

Decision of School Research Ethics sub-Committee

Code 0. Not reviewed- Self certification (proceed with study, following procedures within your local Trust/HA).

Signed _____ (Chair of School Research Ethics sub-Committee)

Code 1. Pass- Approval with no amendments. Continue with study (proceed with study, following procedures within your local Trust/HA).

Signed _____ (Chair of School Research Ethics sub-Committee)

Code 2. Pass - Approval with minor amendments. Supervisor to monitor proceed with study, following procedures within your local Trust/HA). You are strongly advised to follow the

recommendations as follows:

1) Please proof read your work

Signed ____ H Paniagua and D Chadwick ___ (Chair of School Research Ethics sub-Committee)

Appendix N – Workshop presentation

AGREED SHARING

- Confidentiality (what we discuss in the room stays in the room)
- Respecting others opinions, beliefs, culture and experiences
- Not talking over others
- No pressure to talk
- Feel free to take 'time out'

- Anything else you would like to add?

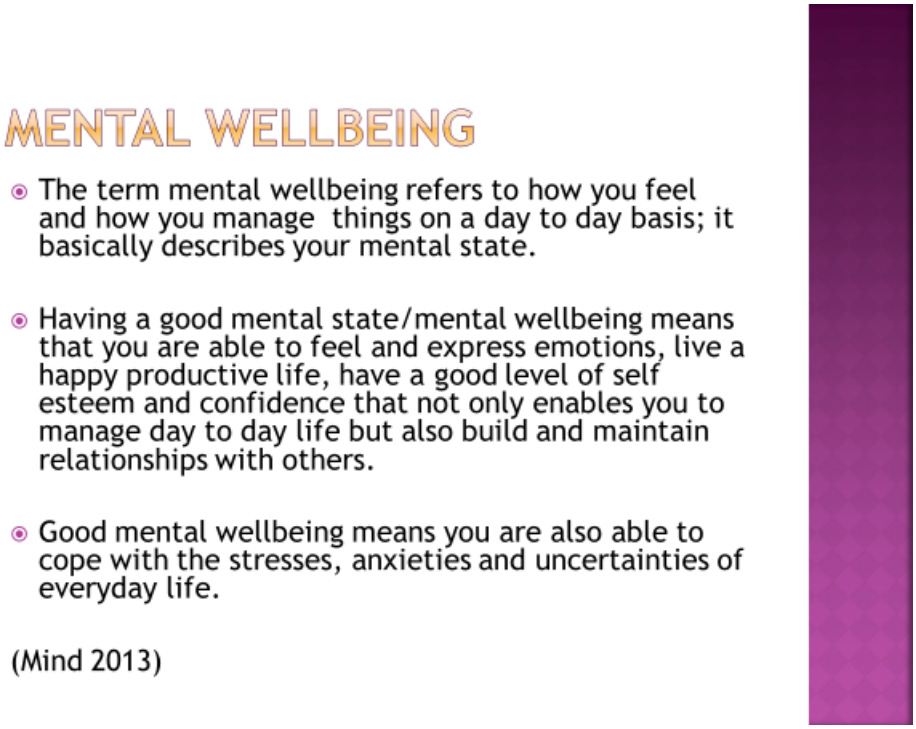
WHAT YOU CAN EXPECT

- Opportunity to learn more about mental/emotional wellbeing and how to manage this
- Possible causes of mental ill health
- Exploration of the different types of mental ill health
- Types of support/services available
- An introduction to my research

MENTAL WELLBEING

- **What does the term 'mental wellbeing' mean to you?**

- discuss in pairs and feedback to the group


MENTAL WELLBEING
The term mental wellbeing refers to how you feel and how you manage things on a day to day basis; it basically describes your mental state.
Having a good mental state/mental wellbeing means that you are able to feel and express emotions, live a happy productive life, have a good level of self esteem and confidence that not only enables you to manage day to day life but also build and maintain relationships with others.
Good mental wellbeing means you are also able to cope with the stresses, anxieties and uncertainties of everyday life.
(Mind 2013)

MENTAL WELLBEING

- Having bad or low mental health may mean that you may be feeling low in mood, constantly worried or distressed, struggling to cope with everyday life or even struggling to maintain relationships.

- We can all experience the above during our lifetime, especially if faced by difficult life circumstances.

- **However some situations or factors may make an individual more likely to experience low mental wellbeing, can you think of any?**

MENTAL WELLBEING

- Physical or sexual abuse (as a child or as an adult)
- Trauma (as a result of a serious accident or violence)
- Neglect
- High levels of stress
- Practical issues such as poor housing, unemployment, poverty or debt
- Physical health conditions
- Alcohol or drug misuse

Sometimes, when low mental wellbeing is experienced over a long period of time, mental health problems can develop.

TYPES OF MENTAL HEALTH PROBLEMS

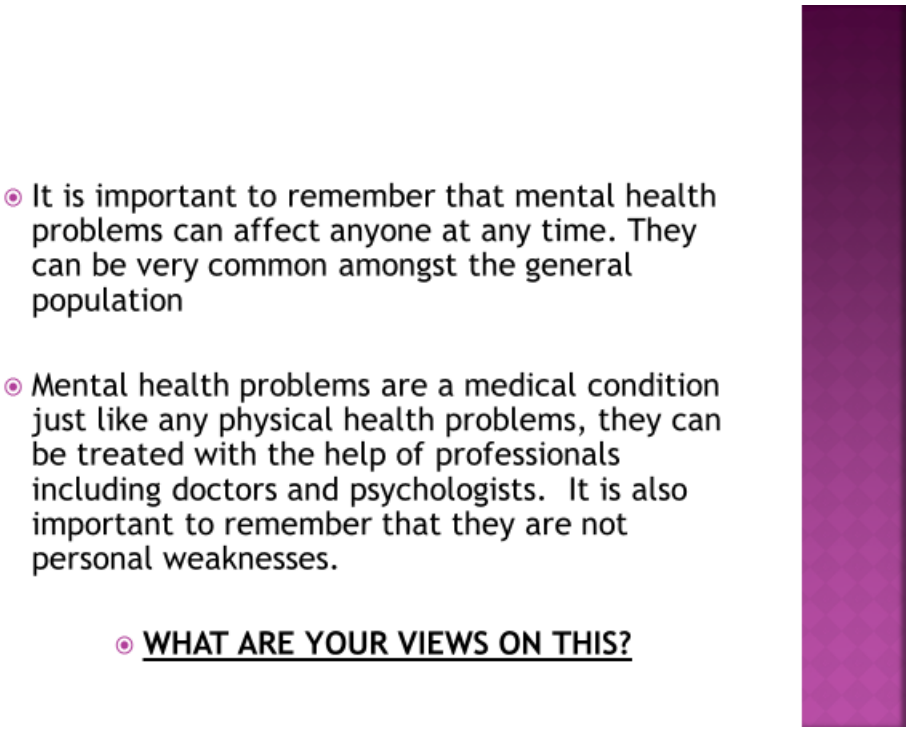
Common Mental health problems include:

- Depression
- Anxiety
- Panic

More severe mental health problems include:

Schizophrenia
Psychosis
Phobias
Bi-polar

(NICE 2014)


It is important to remember that mental health problems can affect anyone at any time. They can be very common amongst the general population
Mental health problems are a medical condition just like any physical health problems, they can be treated with the help of professionals including doctors and psychologists. It is also important to remember that they are not personal weaknesses.
WHAT ARE YOUR VIEWS ON THIS?


HOW CAN YOU MANAGE YOUR MENTAL WELLBEING
There is some evidence to suggest that by following the five steps below you can improve your mental wellbeing (NHS 2014)
connect - connecting with people around you and developing relationships.
be active - making enjoyable activities part of your daily routine
keep learning - learn new skills that give you satisfaction and pleasure
give to others - small acts like a smile or larger acts such as volunteering with a charity
take notice - being aware of feelings, thoughts, body and the world around you in the present moment
Can you think of anymore?

TYPES OF SUPPORT AVAILABLE

- If you have been experiencing low mental wellbeing for a period of time, or experience specific mental health problems the following types of support are available:

- **Your G.P**: usually you first port of call. Medication or talking therapies may be an option

- **Community mental health teams -** team can include a community psychiatric nurse, social worker or support worker

- **Residential care** – Short term or long term care

- **Hospital treatment/crisis intervention-** this would only be the case for severe and complex mental health problems

- Mind (2013)

AN INTRODUCTION TO MY RESEARCH

- I conducted some research into the mental health help seeking experiences of British Born, South Asian women. I carried out interviews with these ladies to get a better understanding of the mental health problems they experienced, the kind of help they sought and how they overcame any barriers and successfully accessed therapeutic help.
- Thus I was focusing on the positive outcomes of therapy; something which I feel is usually overlooked.
- I found some very interesting themes amongst the data I collected and I would like to share some of these with you:

AN INTRODUCTION TO MY RESEARCH

1. **Therapy as a positive experience** - This theme describes the participants' experiences of therapy as being a positive and beneficial one. It describes the different elements of the therapeutic experience.

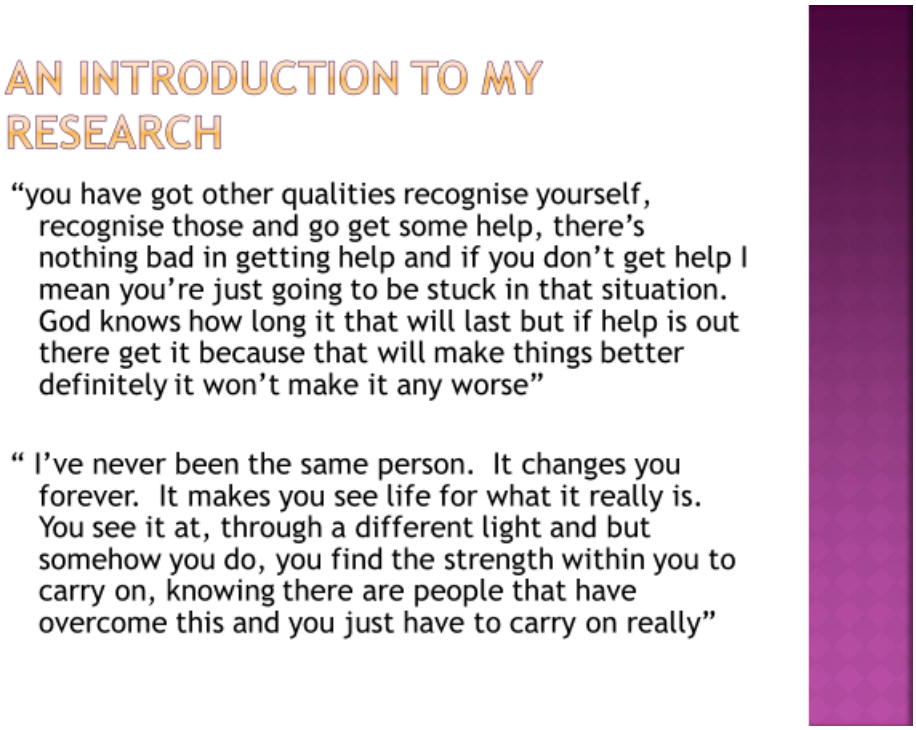
AN INTRODUCTION TO MY RESEARCH

"It was, it is quite helpful, I look forward to come here because they are non judgemental, they understand your situation and it's a third party. And they try to explore your circumstances and give you more support, try to build my confidence here and that's it…"

"it was sort of she didn't focus on one thing if that makes sense she sort of went deeper into into the whole issue that happened and sort of made me see it from a different perspective because in my head I was blaming myself"

AN INTRODUCTION TO MY RESEARCH

- *"there is help there and it doesn't give you a bad name, it doesn't make you horrible it doesn't it's not disgraceful, you're seeking help it's like going to the doctor because you've got an illness that's not your fault, you're going there because you've got this illness and you're going to be cured"*


AN INTRODUCTION TO MY RESEARCH
"you have got other qualities recognise yourself, recognise those and go get some help, there's nothing bad in getting help and if you don't get help I mean you're just going to be stuck in that situation. God knows how long it that will last but if help is out there get it because that will make things better definitely it won't make it any worse"
" I've never been the same person. It changes you forever. It makes you see life for what it really is. You see it at, through a different light and but somehow you do, you find the strength within you to carry on, knowing there are people that have overcome this and you just have to carry on really"

AN INTRODUCTION TO MY RESEARCH

"Yeah, I mean within six months I saw for myself how much I'd moved on, spiritually and mentally, I had overcome things and even if I have to go over things we did, but as a person I saw myself grow from when I first stepped into the office and then six months after and I look back, and I think wow, even the professional herself turned round and said, I've seen you come on, leap and bounds, yeah"

AN INTRODUCTION TO MY RESEARCH

2. Perseverance and persistence - This theme illustrates the participants' emphasis on the kind of persistence and perseverance they needed in order to access help.

AN INTRODUCTION TO MY RESEARCH

"It was just persistence, it's just your mind you've got to put your mind to it. If you don't and you let whatever it is get in the way then you're not going to get anywhere"

" I had that determination and let them talk what they're talking about it, I'm just going to keep on trying"

"you know just carry on, never give up. There's always something there that you will get through it. Nothing's ever that difficult and just carry on"

AN INTRODUCTION TO MY RESEARCH

3. **Need to know basis -** This theme describes participants' experiences of limiting the amount of people they told about their help seeking.

AN INTRODUCTION TO MY RESEARCH

"I didn't tell them. I just said I'm going out. I didn't talk about my business it's the only way you can deal with it with Asian families anyway it's the best way you-it-because I'm old enough now they don't need to know my business"

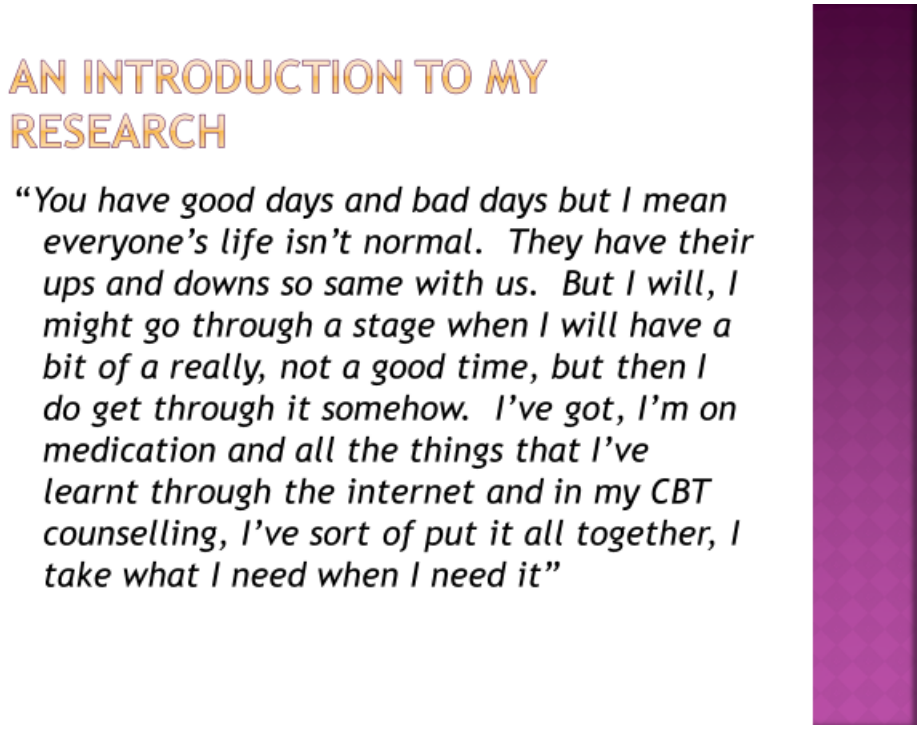
"That was amazing I I was actually a bit reluctant to begin with because that was the first time ever I got counselling but it's all confidential you sign the papers and you know that no one else is going to know about what you've done"

AN INTRODUCTION TO MY RESEARCH

4. **Recovery as an ongoing process** - This theme describes participants' experiences of recovery being an ongoing and continuous process.

AN INTRODUCTION TO MY RESEARCH

"and you might have days where you go ten steps back but just try you know eventually you will get there. I'm going through the process now, it's not easy you know I have bad days and along with all the problems obviously the body can't cope and you do get ill and stuff, but you know what nobody's perfect"


AN INTRODUCTION TO MY RESEARCH
"You have good days and bad days but I mean everyone's life isn't normal. They have their ups and downs so same with us. But I will, I might go through a stage when I will have a bit of a really, not a good time, but then I do get through it somehow. I've got, I'm on medication and all the things that I've learnt through the internet and in my CBT counselling, I've sort of put it all together, I take what I need when I need it"

AN INTRODUCTION TO MY RESEARCH

5. **Developing autonomy and putting your own needs first** - This theme illustrates the importance participants placed on developing their autonomy during the help seeking process.

AN INTRODUCTION TO MY RESEARCH

"But also I try and balance it out by doing things to keep myself well, trying to eat well, keep, do exercise, have a social life, keep a healthy balance and then keeping in touch, a healthy form of contact with my family"

"Yeah. I just done whatever I could. I was going to do anything to help myself. So I just kept researching. How do I help myself and how I'm going to get through this?"

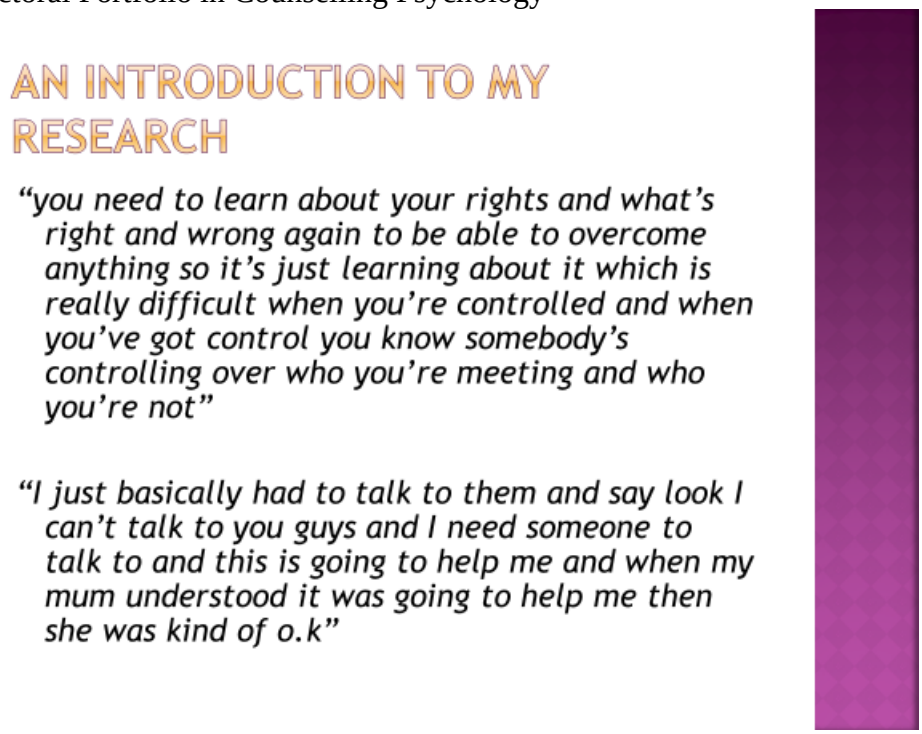
AN INTRODUCTION TO MY RESEARCH

"I took a vow that, that's it, it's only, what's happened, it's in the past, you can move forward and you're going to look after yourself and you're going to put yourself first"

- *"I knew where to start and how to get help basically and I knew I had to start off with myself, look after myself and then look after the children"*

AN INTRODUCTION TO MY RESEARCH

6. **Developing understanding** - This theme describes the importance participants' gave to developing understanding about cultural attitudes to mental illness and help seeking.


AN INTRODUCTION TO MY RESEARCH
"you need to learn about your rights and what's right and wrong again to be able to overcome anything so it's just learning about it which is really difficult when you're controlled and when you've got control you know somebody's controlling over who you're meeting and who you're not"
"I just basically had to talk to them and say look I can't talk to you guys and I need someone to talk to and this is going to help me and when my mum understood it was going to help me then she was kind of o.k"

AN INTRODUCTION TO MY RESEARCH

"I think, I think they should do, whatever they're going through, they should read about it and they should make their family members understand. They need to give them the information and the knowledge. Say look, this is this, I need help and I need to, you need to understand this. So they need, she needs, they need to, she needs to teach her family members that this is something that needs, I need help with. She needs to make them understand"

AN INTRODUCTION TO MY RESEARCH

7. **The first step** - This theme illustrates the importance of taking that first difficult but crucial step in accessing help.

"you can get yourself up again but you need to make that first step and have the guts to try and you shouldn't be scared of anyone"

"I'm now turning my life around to build a new chapter in my life, so I, I, I feel empowered, I took the first step, but I knew I needed the help"

"Find the courage, find the courage and make that first move, if it's something that you really, really don't want in your life and you know it's, it's destroying you, make that first move, you'll never regret it. You know consequences, there might be consequences but as long as it's not at your expense but make that first move, don't suffer in silence, a lot of women do don't they, but don't suffer in silence, get help, I'd say that"

" It's not easy but once you do get on that ladder it keeps getting better yeah In some ways yeah it's not easy but it helps"

- Any questions or feedback?

- Thank you ☺

REFERENCES

- Mind (2013) Mental health problems. Retrieved 5th Jan 2015, from http://www.mind.org.uk/information-support/what-are-mental-health-problems
- NICE (2014) Guidance. Retrieved 5th Jan 2015, from http://www.nice.org.uk/guidance/cg123
- NHS (2014) Five steps to mental wellbeing. Retrieved 5th Jan 2015 from http://www.nhs.uk/Conditions/stress-anxiety-depression/Pages/improve-mental-wellbeing.aspx

Appendix O – Letter sent out to relevant organisations

Dear Sir/Madam

My name is Mehmoona Ashiq and I am a trainee Counselling Psychologist at the University of Wolverhampton. I am conducting some research into the mental health help seeking experiences of British Born South Asian women. I am therefore writing to ask if you have worked with any women that fit the criteria of this research, who you believe may be willing to take part in this research.

The research will initially involve carrying out qualitative interviews with women aged between 18-45. The main aim will be to explore the types of mental health problems they experienced, the kind of help they sought, the barriers they faced and more importantly, how they overcame these barriers and successfully accessed therapeutic help. The themes generated from these initial interviews will then be fed into a psycho-educational group which will be used to encourage other women who may be in similar positions, to access help. Thus this project is focusing on the positive outcomes of therapy and aims to help shape and influence future service provision and tackle the issue of low service uptake by South Asian Women.

I have completed the first part of this study (interviews) and I am now recruiting participants for the second part (psycho-educational group). I am hoping that you may be able to help me in

recruiting participants for this part of the study. I am looking to recruit women aged between 18-45, from a South Asian background who may be at risk of psychological distress. Ideally I am looking for participants who could benefit from accessing therapeutic help but are reluctant to do so; this may be as a result of possible barriers they face in accessing this help. Participant's involvement in the study will involve taking part in a psycho-educational group which will take place in a local community setting and will last approximately an hour and a half. Participants will also be asked to complete a questionnaire before, immediately after and two or four weeks after the group. This latter questionnaire will be completed at a mutually convenient time and place for the participant and the researcher.

If you know of any women who may be appropriate for this study, I would appreciate if you could contact these women and speak to them about the research, and pass on my contact details should they express an interest in taking part.

This research project has been approved by the University's Faculty of Education Health and Wellbeing Ethics Committee. The research will be carried out under the supervision of Dr Richard Darby and Dr Victoria Galbraith.

Please do not hesitate to contact me if you require any further information and I look forward to hearing from you in the future.

Yours sincerely,

Mehmoona Ashiq

Trainee Counselling Psychologist

Mehmoona.Ashiq@wlv.ac.uk

07722061708

Appendix P - Poster used to recruit participants

Help seeking experiences of British born South Asian Women: Overcoming the barriers

Are you a British Born South Asian woman, aged between 18-45?

At any point in your life have you felt that you could benefit from accessing therapeutic help (E.g. seeing a Psychologist or a counsellor)?

Have you ever felt reluctant to access help due to perceived barriers in doing so?

If the answer is yes to any of the above questions, then I would like to hear from you!

Mehmoona Ashiq
Doctoral Portfolio in Counselling Psychology

My name is Mehmoona Ashiq and I am a trainee Counselling Psychologist at the University of Wolverhampton. I am doing some research into how South Asian Women successfully overcome barriers to access therapeutic help.

If you feel that you would like to take part in this research then please contact the centre and leave your contact details. I will then contact you and arrange to meet at a mutually convenient time and place, where I will explain the research and your possible participation in more detail.

Mehmoona Ashiq

Trainee Counselling Psychologist

Appendix Q – Participant information sheet

Participant Information Sheet

- This sheet will be given to participants to read, if they cannot read, then the researcher will read this out to the participant and ensure they have understood everything on it.

Participant Information Sheet Part B

This information sheet will provide you with information on the research project that you have been asked to take part in. It will give you enough information to decide whether or not you wish to take part. This project is being carried out by Mehmoona Ashiq, a trainee Counselling Psychologist at the University of Wolverhampton. This research is being supervised by Dr Richard Darby and Dr Victoria Galbraith. The research has received ethical clearance from the University of Wolverhampton's Faculty of Education Health and Wellbeing Ethics Committee.

The aim of this research is to get a better understanding of the barriers that British Born South Asian women face in accessing therapeutic help for mental health issues. More

importantly however, it aims to get an understanding of how they overcome these barriers and go on to successfully access help. The research will also involve measuring the effectiveness of an emotional wellbeing awareness group on attitudes and willingness towards help seeking. Potential risks of this study are minor and could possibly include slight emotional disturbance or questioning your own beliefs regarding mental health.

If at any point during the group or completion of the questionnaires, you find it distressing to talk about your experiences, then we can stop the process. If you continue to feel distressed you should contact your G.P in the first instance or you can contact the Samaritans, who provide 24 hour telephone support for people experiencing emotional distress, on 08457 90 90 90 .

Your participation in this research will involve taking part in an emotional wellbeing awareness group that will last approximately an hour and a half. You will also be asked to complete a questionnaire before, immediately after and two weeks after the group. The questionnaire completed after two weeks, will be carried out by arranging a meeting with yourself and the researcher at a mutually convenient time and place.

If you agree to take part, you will have an opportunity to speak to the researcher to clarify any queries you may have before the group is carried out; you will then sign a consent from. However, you participation is entirely voluntary, and even after you have signed the consent form you are free to withdraw from the research, up until the data is analysed, without having to give a reason. It will not be possible to withdraw your data from the research once analysis has begun, as the researcher will be working towards a deadline for completion of the research in order to pass the course.

Your participation in this research will remain entirely anonymous. Your name or any identifying information about you will not be collected. It will not be possible to link you to your responses on the questionnaire. The data will be kept strictly confidential and where necessary, a number or code name will be used to report the data. Your responses to the questionnaire will be viewed by the researcher (Mehmoona Ashiq), the supervisors (Dr Richard Darby and Dr Victoria Galbraith) and external examiners.

During the process of the research, data will be stored on a password protected laptop which can only be accessed by the researcher. This will be stored in a locked cabinet when not in use. Once the research project has been completed, the researcher aims to submit it for publication in relevant academic journals. The responses will be kept in a secure place by the researcher and will be destroyed within three years of the research completion.

Please do not hesitate to ask the researcher (Mehmoona.Ashiq@wlv.ac.uk) or her supervisor (R.Darby@wlv.ac.uk) if you require any further information about this project.

Thank you for taking the time to read this sheet and for expressing an interest in taking part.

Appendix R - Consent form

- This sheet will be given to participants to read and complete. If they cannot read, the researcher will read this out to the participant, ensure they have understood everything on it and help them to complete it.

Participant Consent Form Part B

Research project title: **Mental Health help seeking experiences of British South Asian Women: Overcoming the barriers**

Researcher name: **Mehmoona Ashiq**

***Please initial each box**

8. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask any questions

☐

9. I understand that my participation in the research is completely voluntary and that I am free to withdraw from the research up until the interview is analysed, without having to give a reason.

☐

10. I understand that any identifiable information will be anonymised.

☐

11. I understand that during the process of the research, data will be stored on a password protected laptop which can only be accessed by the researcher. This will be stored in a locked cabinet when not in use. The researcher will destroy the responses within three years of the research completion.

☐

12. I understand that once this research is complete, it will be submitted for publication in various academic journals.

☐

13. I agree to take part in the above research.

☐

Name or initials of Participant ……

Signature or initials of Participant …….....

Date …….

Researcher signature ……

Appendix S – Demographic questionnaire

Demographic Questionnaire

- This sheet will be given to participants to read and complete. If they cannot read, the researcher will read this out to the participant, ensure they have understood everything on it and help them to complete it.

This form is optional to complete

Please fill out the following information

Age……

What South Asian subgroup do you belong to? (please circle)

Indian Pakistani Bangladeshi Sri Lankan

Other…….

Marital Status (please circle)

Married Single Divorced Widowed Separated Co-habiting

What is your education level?

……

Have you ever felt that you would benefit from accessing therapeutic help (E.g. a Counsellor/Psychologist)? (please circle)

Yes No

Has a professional (e.g. your G.P) ever suggested to you that you should consider accessing therapeutic help? (please circle)

Yes No

Have you ever accessed therapeutic help? (please circle)

Yes No

Appendix T – Debrief Sheet

- This sheet will be given to participants to read, if they cannot read, then the researcher will read this out to the participant and ensure they have understood everything on it.

Debrief sheet Part B

Research project title: **Mental Health help seeking experiences of British South Asian Women: Overcoming the barriers**

Thank you for taking part in the above research project.

The aim of this research is to get an understanding of how British born South Asian Women are able to overcome any barriers they may face, and go onto successfully access therapeutic help. Themes generated from interviews carried out with women who have successfully overcome barriers and accessed therapeutic help, were presented in an emotional wellbeing awareness group in order to examine the impact this could have on attitudes and willingness to seek therapeutic help .

If your participation in this research has generated any feelings of distress then please contact your G.P or the Samaritans on 08457 90 90 90. You can also contact specific services in Birmingham such as Women's Aid on 0121 685 8687 or My time (provides culturally sensitive counselling and support) on 0121 766 6699.

If you would like any further information, express any concerns or like to see this research project once it has been completed, then please do not hesitate to contact the researcher (Mehmoona.Ashiq@wlv.ac.uk) or her supervisor (R.Darby@wlv.ac.uk).

Thank you once again for your valuable contribution to this research project.